Supreme Court, U.S.
FILED

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No.

In The

Supreme Court of the United States

October Term, 1995

WILLIAM A. RAMSEY, JR.

Petitioner,

versus

THE COLONIAL LIFE INSURANCE COMPANY OF AMERICA D/B/A CHUBB LIFEAMERICA,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

PETITION FOR WRIT OF CERTIORARI

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August 1, 1996

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QUESTION PRESENTED

The Eighth, Ninth, Tenth and Eleventh Circuits apply and accept equitable estoppel in ERISA cases where the insurer makes representations and gives the plan participant erroneous advice based on ambiguous policy provisions to the plan participant's legal detriment. The Fifth Circuit refuses to apply or accept the federal common law doctrine of equitable estoppel in such ERISA cases.

The issue presented is whether an ERISA plan insurer (Colonial Life Insurance Company), which terminated coverage to a permanent quadriplegic plan participant (Ramsey), relying on ambiguous provisions in its ERISA plan group major medical policy, should be allowed to totally avoid payment of benefits denied Ramsey during the pendency of the action, including appeals, where the benefits which were denied, but for the insurer's reliance on the ambiguous policy provisions, would have been paid. Does ERISA supplant the normal rules of construction for the Colonial policy to preclude Ramsey's recovery of the value of benefits based on Colonial's interpretation of its ambiguous policy, where Colonial lost its coverage denial on appeal? Should federal common law equitable estoppel be applied to prevent the plan participant from being denied benefits and the insurer granted a windfall, where the District Court dismissed and the Fifth Circuit on appeal affirmed the dismissal on erroneous procedural grounds?

LIST OF PARTIES TO PROCEEDINGS IN DISTRICT COURT AND FIFTH CIRCUIT

1. Plaintiff/Appellant, William A. Ramsey, Jr.

2. James W. Nobles, Jr., Jackson, Mississippi, and Pat Barrett, Jr., Lexington, Mississippi, Attorneys for William A. Ramsey, Jr.

3. Defendant/Appellee/Cross-Appellant, The Colonial Life Insurance Company of America which has entities directly related as follows:

   Chubb Life Insurance Company of America,
   Parsippany, New Jersey
   Chubb Sovereign Life Insurance Company
   Chubb Securities Corporation
   Hampshire Funding, Inc.
   Hampshire Syndications, Inc.
   Chubb America Service Corporation
   Chubb Investment Advisory Corp.
   Volunteer Garage Company, Inc.

4. Robert C. Boyd
   Boyd & Akin
   Jackson, Mississippi, Attorney for Defendant/Appellee Colonial Life Insurance Company of America.

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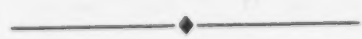
STATEMENT OF JURISDICTION

This is an appeal pursuant to Rule 10(a) of the Supreme Court Rules, for Writ of Certiorari from the Judgment of United States Court of Appeals for the Fifth Circuit dated May 3, 1996, affirming the United States District Court for the Southern District of Mississippi, dismissing Ramsey's Post Appeal Action to Quantify Declaratory Judgment, pursuant to 28 U.S.C., Section 2202, where the Ruling of the Fifth Circuit conflicts with decisions involving denial of coverage benefits under ERISA plan policies drafted by the insurer was ambiguous and where other Circuits apply equitable estoppel to allow the plan participant to recover benefits, and the Fifth Circuit does not. This Petition For Writ of Certiorari is filed within 90 days from entry of the Fifth Circuit's Order and Judgment.

This Court has jurisdiction to review the Judgment of the Federal Court of Appeals for the Fifth Circuit, pursuant to 28 United States Code, Section 1254(1) upon the granting of Petition of Writ of Certiorari after rendition of judgment or decree.

STATUTES APPLICABLE

Employment Retirement Income Security Act (ERISA) Sections 502(1)(b) and 514(a), 29 U.S.C. Section 1144(a), applicable to Plan Participants benefits which are wrongfully denied by the insurer based on ambiguously worded insurance policies which comprise the plan.



CONCISE STATEMENT OF THE CASE

William A. Ramsey, Jr. is a quadriplegic who sustained permanent paralysis on January 31, 1987, while he was a covered dependent under his wife's Moulden Supply Company Major Medical Group Insurance Policy issued by The Colonial Life Insurance Company. Until July 31, 1990, when Colonial Life wrongfully terminated Ramsey's coverage, Colonial paid benefits for medical expenses, sixteen hours per day attendant care expenses, and other medical benefits under the policy. Ramsey is unquestionably permanently and totally disabled and requires attendant care on a daily basis for the remainder of his life due to the quadriplegia which allows him to move only his head. Colonial denied coverage and denied claims on and after July 31, 1990 on the basis that Ramsey's coverage ceased when the Moulden Supply Company group policy was canceled.

Ramsey filed an action in the Mississippi State Court for Declaratory Judgment and common law and contract based actions for damages for the wrongful cancellation of coverage and denial of benefits, for actual and punitive damages and attorneys' fees. The cause was removed to the United States District Court for the Southern District of Mississippi, which recast the pleadings to make the action come under the terms and provisions of ERISA. On Motion for Summary Judgment the District Court granted Ramsey a Declaratory Judgment holding that the attempted cancellation by Colonial was ineffective, because under the ambiguous provisions relied on by Colonial, Ramsey's permanent total disability prevented his coverage from ceasing and that Ramsey's coverage remained in effect as if it had never been canceled.

Ramsey v. Colonial Life Ins. Co., 843 F. Supp. 1103 (S.D. Miss. 1992). The District Court denied Ramsey's request for Attorneys' Fees and entered judgment dismissing all other claims. Ramsey appealed to the Fifth Circuit on the denial of attorneys' fees issue. Colonial cross-appealed on the issue of coverage, thereby continuing its contest of coverage for Ramsey.

The Fifth Circuit, affirming the District Court, see: *Ramsey v. Colonial Life Insurance Company of America*, 12 F.3d 472 (5th Cir. 1994) Ramsey I, found that Colonial had wrongfully denied coverage based on the ambiguities contained in the Moulden Supply Company issued to Ramsey's wife, which covered Ramsey. This affirmance occurred almost four years after Colonial Life denied further coverage to Ramsey and denied claims which occurred after July 31, 1990 on the ground that coverage ceased.

Subsequent to the affirmance of the District Court by the Fifth Circuit, Ramsey filed his Motion to Quantify Prior Judgment and for Declaratory Relief seeking to have the District Court quantify the value of the benefits which Ramsey would have received under Colonial Life's policy for attendant care and covered related medical expenses, which Colonial Life had paid, prior to its denial of coverage. These attendant care services were provided, in part, by the state of Mississippi, and by Ramsey's wife and children. Colonial denied that it owed any monies for these attendant care services and other medical expenses because the same were not "incurred" and submitted to it during the hiatus of the policy coverage brought on by its denial.

The District Court dismissed Ramsey's Motion to Quantify Prior Judgment and entered judgment in favor of Colonial Life because Ramsey did not "incur" expenses and submit claims for services rendered during the time that Colonial denied coverage and appealed the District Court's judgment restoring coverage, holding that Ramsey should have presented all the claims which had accrued in the original action, which the District Court had dismissed, and from which Ramsey had not appealed, meaning that Ramsey's claims were dismissed on procedural, rather than substantive grounds.

Ramsey appealed to the Fifth Circuit, which, per curiam, affirmed the District Court, on procedural grounds, holding, in effect, that Ramsey failed to appeal the District Court's denial of benefits in *Ramsey I*, supra, and that Ramsey had his "bite at the apple" in the first action and was therefore precluded from seeking recovery, even though benefits were denied for four years from July 31, 1990 until January, 1994 when *Ramsey I*, supra, was rendered, on the basis that Ramsey "abandoned" his right to recover these lost benefits which were terminated by affirmance in *Ramsey I*, supra, and that equitable estoppel principles could not be used as a vehicle to recover the benefits, which were wrongfully denied.

Ramsey v. Colonial Life Insurance Company of America, 85 F.3d 625 (5th Cir. 1996) (Ramsey II) refused to apply equity to allow Ramsey to recoup the value of the benefits denied by the wrongful cancellation of coverage by Colonial Life Insurance Company, even though the attendant care and medical expenses were incurred and occurred during the pendency of the action and the appeal in *Ramsey I*, supra, and were not legally due until

the Fifth Circuit's affirmance on Cross-Appeal the coverage which Colonial contested through *Ramsey I*, supra.

Ramsey's Affidavit, which is incorporated in the Appendix, details the methods by which he continued to exist, in spite of the wrongful cutoff of his benefits by Colonial.

Jurisdiction of the action is based on 28 U.S.C. Section 2208, 28 United States Code, Section 1331 (Federal Question) and the Appeal from the United States District Court for the Southern District of Mississippi to the United States Court of Appeals for the Fifth Federal Circuit, pursuant to Rule 3(a) of the Federal Rules of Appellate Procedure.

ARGUMENT

Equitable Estoppel has been applied by the Eighth, Ninth, Tenth and Eleventh Circuits in allowing the plan participant to recover benefits wrongfully denied by reliance by the Plan Participant to his detriment on representations made to his detriment with regard to ambiguous language in a benefit plan. See: *Qualls, by and through Qualls v. Blue Cross of California, Inc.*, 22 F.3d 839 (9th Cir. 1994); *Greany v. Western Farm Bureau Life Ins. Co.*, 973 F.3d 812, 821 (9th Cir. 1992); *Averhart v. U S West Management Pension Plan*, 46 F.3d 1480 (10th Cir. 1994); *Kane v. Aetna Life Ins. Co.*, 893 F.2d 1283 (11th Cir. 1990) cert. denied 498 U.S. 890, 111 S.Ct. 232, 112 L.Ed.2d 192 (1990); *Hostetter v. United Omaha Life Insurance Company*, 33 F.3d 1341 (11th Cir. 1994); *Alday v. Container Corp.*, 906 F.2d 660, 666 (11th Cir. 1990).

The Eighth Circuit has recognized the equitable estoppel doctrine to be applicable where policy language drafted by the insurer is ambiguous and is interpreted erroneously by the insurer to deny benefits under an ERISA plan. See: *Landro v. Glendenning Motorways*, 625 F.2d 1344, 1355 (8th Cir. 1980).

Here, Ramsey was denied coverage and led to his detriment not to file claims during the pendency of the litigation by Colonial's advice that his coverage had ceased. Even though Ramsey had attorneys representing him, Colonial's wrongful denial of coverage and its position that no further claims were covered under the Moulden Policy and that it would not accept claims for payment, put Ramsey in the position of being denied his coverage and his ability to present claims for payment based on Colonial's erroneous interpretation of its ambiguous policy and its representations to Ramsey that coverage had ceased under Colonial's ambiguously worded policy.

The refusal of the Fifth Circuit to recognize the equitable nature of Ramsey's claims for wrongfully denied benefits is in conflict with the Eighth, Ninth, Tenth and Eleventh Circuits. *Ramsey II*, supra, effectively allows an insurer, on procedural grounds, to deny coverage under its ambiguously worded policy, suspend the acceptance of claims and refuse to pay benefits, lose its appeal on that denial of coverage and avoid payment of the benefits to Ramsey, which clearly never ceased to be needed. Such is a windfall for Colonial and is a total miscarriage of justice. Congress never had in mind such an arrangement when ERISA was enacted into law. Ramsey, without any monies to pay for attendant care, wheel chair and medical

supplies needed for his quadriplegia, turned to the state and to his family to provide same. Colonial refused to pay benefits for the same supplies, services and medical expenses for Ramsey, which it paid from January 31, 1987 until it refused further coverage on July 31, 1990. Colonial's claims personnel clearly and unquestionably knew that Ramsey's quadriplegic state required the continued payment of the bills for medical supplies, medical treatment and equipment and attendant care, none of which will cease until Ramsey's demise. Colonial Life has been allowed to reap the benefits of the seeds of its inequitable conduct and by the Fifth Circuit's affirmance in *Ramsey II*, supra, allowed to avoid payment of Ramsey's claims which were incurred.

The District Court held in the Ramsey's original action, that the coverage never ceased and that Colonial's attempted cancellation of the coverage available to Ramsey was ineffective. When presented with the affirmance by the Fifth Circuit in *Ramsey I*, supra, the District Court denied Ramsey and relief for the attendant care services and medical expenses which were unquestionably received by Ramsey and incurred by him. The District Court's dismissal of all Ramsey's then existing claims for benefits, precluded his recovery after affirmance by the Fifth Circuit, Ramsey's attendant care services and medical supplies and equipment were ongoing. Ramsey is therefore, rendered without a remedy for benefits which accrued from the District Court's judicial determination that Ramsey's coverage had been wrongfully denied by Colonial's denial of coverage under the Moulden Policy to the affirmance of *Ramsey I*, supra.

The Fifth Circuit totally ignored the equitable basis for Ramsey's claims and chose instead to affirm the District Court on procedural grounds which were erroneous. The affirmance in *Ramsey II*, supra, rings hollow when the question is asked, what did Ramsey accomplish in *Ramsey I*, supra, other than to have benefits resume in 1994, after being denied for four long years while Colonial continued to deny coverage, even on its cross-appeal.

In *Qualls, by and through Qualls v. Blue Cross of California, Inc.* supra, the Ninth Circuit held:

> This circuit "has recognized that federal equitable principles can, in certain circumstances, apply to some claims arising under ERISA." Greany v. Western Farm Bureau Life Ins. Co., 973 F.2d 812, 821 (9th Cir. 1992). These circumstances, however have been limited to situations in which an employee relied to his detriment on representations made with regard to ambiguous language in a benefit plan. Id. at 821-822"

The Fifth Circuit, as well as the District Court, found in *Ramsey I*, supra, that Colonial's policy was ambiguous and ruled that coverage never ceased for Ramsey. How then, can equitable estoppel not be applied? Where is the substance to the meaning of the District Court's words which granted Ramsey summary judgment against Colonial Life, that coverage never ceased, and the ruling of the District Court that the claims which were precluded by the Summary Judgment Order, were only those claims which were incurred during the twelve month period following the purported cancellation by Colonial on July 31, 1990. *Ramsey v. Colonial Life Ins. Co.*, 843 F. Supp, at 1106, supra, Ramsey is therefore left without a remedy,

given the procedural snafu caused by his failure to appeal something he won in the first place, and now finds himself in a position of not having an adequate remedy at law, for which equity is the answer.

CONCLUSION

William A. Ramsey, Jr. respectfully submits that he was denied equitable treatment by the Fifth Circuit on procedural grounds and on its denial of the remedy based on equitable estoppel as allowed by at least four other Circuits. This Honorable Court should grant his Petition For Writ of Certiorari to settle a substantial question of law about which there are conflicts between the Courts of Appeal for the Federal Circuits as to the applicability of the federal common law doctrine of equitable estoppel as it applies to ERISA plans and benefits which are wrongfully denied on the basis of advice from the insurer grounded on ambiguously worded policies.

Respectfully submitted,

JAMES W. NOBLES, JR.
Attorney for William A. Ramsey, Jr. Petitioner

PETITIONER RAMSEY'S INDEX TO APPENDIX TO RECORD EXCERPTS ON APPEAL

(1) May 3, 1996 Opinions and Judgment of the United States Court of Appeals for the Fifth Federal Circuit, affirming the Judgment of the United States District Court for the Southern District of Mississippi (Order and Judgment appealed from) .....App. 1

(2) Other Orders and Opinions Applicable to Case: .....App. 10

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Final Judgment, United States District Court for the Southern District of Mississippi, June 9, 1992.....App. 43

(3) ERISA Statutes – Citation 29 U.S.C. 1001 et seq.

PETITIONER RAMSEY'S INDEX TO APPENDIX TO RECORD EXCERPTS ON APPEAL – Continued

(4) ERISA Statutes – Citation 29 U.S.C. 1144(a)

ERISA Act, §§ 502(1)(b) and 514(a)

(4) Plaintiff's Notice of Appeal to Fifth Circuit from District Court.....App. 66

(5) Ramsey's Motion to Quantify Prior Judgment and For Declaratory Relief .....App. 68

(6) Defendant's Response to Motion to Quantify Prior Judgment and for Declaratory Relief...App. 72

(7) Affadivit of William A. Ramsey, Jr.....App. 76

(8) Moulden Supply Company Group Insurance Policy #330197 issued By The Colonial Life Insurance Company of America, d/b/a Chubb LifeAmerica Which covered William Allen Ramsey, Jr. as a Dependent .....App. 93

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 95-60361

WILLIAM A. RAMSEY, JR.,

Plaintiff-Appellant,

and

DIANNE W. RAMSEY

Plaintiff,

versus

THE COLONIAL LIFE INSURANCE COMPANY OF AMERICA, doing business as Chubb LifeAmerica,

Defendant-Appellee.

Appeal from the United States District Court
For the Southern District of Mississippi
(3:90-CV-452-BN)

(Filed May 3, 1996)

Before POLITZ, Chief Judge, WIENER, and BARKSDALE, Circuit Judges.

PER CURIAM*:

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*Pursuant to Local Rule 47.5, the court has determined that this opinion should not be published and is not precedent except under the limited circumstances set forth in Local Rule 47.5.4.

Plaintiff-Appellant William A. Ramsey (Ramsey) appeals from the district court's denial of his post-judgment, post-appeal "Motion to Quantify Prior Judgment and for Declaratory Relief." Finding no error, we affirm.

I.

FACTS AND PROCEEDINGS

Early in 1987, Ramsey fell from a ladder while working in his yard and fractured his spine. As a result, he suffered permanent and irreversible quadriplegia. None dispute that Ramsey will require medical treatment and care for the remainder of his life.

At the time of Ramsey's fall, his wife, Dianne Ramsey, was covered by a group insurance policy (the group policy) sponsored by her employer, Moulden Supply Co., Inc (Moulden), and issued by Defendant-Appellee Colonial Life Insurance Company of America (Colonial Life). Ramsey was covered as the spouse of a covered employee.

For more than two years following Ramsey's accident, Colonial Life paid his medical bills. Then, in August 1989, Colonial Life drastically increased Moulden's premiums, so Moulden dropped the group policy. The Ramseys accordingly secured from Colonial Life a conversion policy with a strict $20,000 maximum lifetime limit on benefits, significantly lower than the $2,000,000 limit that the group policy provides. In July 1990, Colonial Life began refusing to pay any further medical expenses incurred by Ramsey.

In August 1990, the Ramseys filed suit against Colonial Life in Mississippi state court, alleging state law claims of bad faith refusal to pay benefits and gross negligence with intent to deceive in inducing him to convert to a policy with substantially lower coverage limits. Colonial Life removed the action to federal district court, where the pleadings were recharacterized as a claim for benefits under the provisions of the Employee Retirement Income Security Act (ERISA).[1] Under the reconstituted pleadings, the court dismissed Dianne Ramsey, as well as the state law causes of action, from the suit.

In a final, summary judgment issued in June 1992, the district court held that (1) Ramsey was entitled to continued medical coverage under the group policy until either his disability came to an end or he obtained other insurance; (2) any premiums paid under the conversion policy were unnecessary and should be refunded; and (3) Ramsey was not entitled to recover attorney's fees.[2] The district court also rejected an argument made by Ramsey that the group policy covers expenses for medical services that have not actually been provided. In so doing, the district court expressly found that "the policy, by its

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[1] *See* 29 U.S.C.S. §§ 1001 et seq. (Law. Co-op 1990 & Supp. 1995).

[2] *See Ramsey v. Colonial Life Ins. Co. of Am.*, 843 F. Supp. 1103 (S.D. Miss. 1992) [hereinafter *Ramsey*], *aff'd* 12 F.3d 472 (5th Cir. 1994).

very terms, provides that a specific medical care or service must be 'rendered' before a benefit may be received under the policy."[3]

After the district court's opinion and judgment were filed, Ramsey appealed to this court (*Ramsey I*).[4] All that was appealed, however, was the district court's denial of attorney's fees. Colonial Life cross-appealed from the ruling extending coverage under the group policy. In January 1994, we issued our *Ramsey I* opinion affirming the district court's judgment with regard to both the extension of coverage and the denial of attorney's fees.[5] In that appeal Ramsey failed to raise, and we accordingly did not address, the issue whether the group policy covers expenses for medical services that have not actually been provided.

In September 1994, nine months after we issued our *Ramsey I* opinion, Ramsey filed a motion in the district

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[3] *Ramsey*, 843 F. Supp. at 1109. The district court reasoned:

> The medical benefits section of the Colonial Life policy provides that, "to receive a benefit, you must have covered medical expenses. . . . " Covered medical expenses are defined as "the usual and customary charges for services and supplies. . . . " Usual and customary charges are defined as "those normally charged by the provider for the specific medical care or service rendered." Accordingly, the policy, by its very terms, provides that a specific medical care or service must be "rendered" before a benefit may be received under the policy.

Id.

[4] *See Ramsey v. Colonial Life Ins. Co. of Am.*, 12 F.3d 472 (5th Cir. 1994) [hereinafter *Ramsey I*].

[5] *See id.*

court, asking that court to "quantify and declare the precise amount that defendant is indebted to the plaintiff" pursuant to that court's prior judgment. In his motion, Ramsey once again argued that Colonial Life should pay for medical expenses that he has not actually incurred – an argument that the district court had expressly rejected and that Ramsey did not challenge before us in *Ramsey I*. More specifically, Ramsey's motion posits that Colonial Life owes him the amount that he *would have spent* on medical services, were it not for Colonial Life's wrongful denial of his claims for benefits under the group policy. Ramsey concedes that his family gratuitously provided the services in question.

The district court exercised jurisdiction over Ramsey's motion pursuant to 22 U.S.C. § 2202, which provides for a grant of "[f]urther necessary or proper relief based on a declaratory judgment or decree."[6] The court subsequently denied the motion, noting that the basic issue presented had been expressly considered and rejected in its prior judgment. Ramsey timely appealed to this court.

II.

ANALYSIS

A. Standard of Review

The district court properly considered Ramsey's "motion to quantify judgment" as a motion for further

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[6] Section 2202 reads: "Further necessary or proper relief based on a declaratory judgment or decree may be granted . . . against any adverse party whose rights have been determined by such judgment." *See* 28 U.S.C.A. § 2202 (West 1994).

relief under 28 U.S.C. § 2202, which "merely carries out the principle that every court, with few exceptions, has inherent power to enforce its decrees."[7] The court then denied the motion purely on legal grounds. Accordingly, we review its ruling de novo.[8]

B. The Merits[9]

We hold that the district court properly denied Ramsey's motion. Ramsey had his "day in court" on this

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[7] *Horn & Hardart Co. v. Nat'l Rail Passenger Corp.*, 843 F.2d 546, 548 (D.C. Cir.), *cert. denied*, 488 U.S. 849 (1988).

[8] *See Pro-Eco, Inc. v. Bd. of Cmm'r of Jay County, Indiana*, 57 F.3d 505 (7th Cir. 1995) (reviewing de novo denial on legal grounds of motion for further relief under 28 U.S.C. § 2202); *see also FDIC v. Mmahat*, 960 F.2d 1325 (5th Cir. 1992); *cf. Teas v. Twentieth Century-Fox Film Corp.*, 413 F.2d 1263 (5th Cir. 1969).

[9] Colonial Life argues that res judicata precludes consideration of the issue presented by Ramsey's appeal. Res judicata is appropriate only if four conditions are satisfied:

> First, the parties in *a later action* must be identical to . . . the parties in *a prior action*. Second, the judgment in *the prior action* must have been rendered by a court of competent jurisdiction. Third, the *prior action* must have concluded with a final judgment on the merits. Fourth, the same claim or cause of action must be involved in *both suits*.

U.S. v. Shanbaum, 10 F.3d 305, 310 (5th Cir. 1994) (emphasis added); *see also Eubanks v. FDIC*, 977 F.2d 166 (5th Cir. 1992). As the claim at issue here arose in the context of *same action* in which it was earlier decided, we decline Colonial Life's invitation to apply the doctrine of res judicata to the instant case.

issue four years ago, before the district court issued its opinion and judgment. By failing to challenge the district court's ruling on this question at the time of the initial appeal to this court, Ramsey *abandoned* the issue.[10] He cannot now, nine months after the issuance of our opinion in *Ramsey I*, dust off the argument and recast it as a motion for further relief in the district court.[11] To allow him to do so would fly in the face of several of our foundational principles – namely, that "there must be an end finally to a particular litigation"[12]; that parties should not be encouraged to engage in "trial by ambush,"[13] particularly after the district court's final judgment has been affirmed by this court; and that postjudgment motions are not to be used as substitutes for appeals.[14]

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[10] For examples of cases holding that when a party fails to advance an argument on appeal, the argument is deemed abandoned, see *Justiss Oil Co., Inc. v. Kerr-McGee Refining Corp.*, 75 F.3d 1057 (5th Cir. 1996); *Eason v. Thaler*, 73 F.3d 1322, 1329 (5th Cir. 1996); *Feldt v. Mentor Corp.*, 61 F.3d 431, 437 n.7 (5th Cir. 1995); *Cinel v. Connick*, 15 F.3d 1338, 1345 (5th Cir.), *cert. denied*, 115 S. Ct. 189 (1994).

[11] *See, e.g., Savers Fed. Sav. & Loan v. Reetz*, 888 F.2d 1497, 1501 (5th Cir. 1989) (noting that issues raised in pleadings, but abandoned in opposition to motion for summary judgment, could not be saved by being raised again in motion to reconsider) (citing *Batterton v. Texas Gen. Land Office*, 783 F.2d 1220, 1224-25 (5th Cir.), *cert. denied*, 479 U.S. 914 (1986)).

[12] *See Briddle*, 63 F.3d at 380 (internal quotations omitted).

[13] *See Savers*, 888 F.2d at 1501.

[14] *Cf. Eason*, 73 F.3d at 1329 (holding that district court "exceeded the scope" of a remand when it addressed an issue that had been abandoned on appeal); *Lancaster v. Presley*, 35 F.3d 229, 232 (5th Cir. 1994) (holding that district court properly exercised discretion in denying Rule 60(b) motion that

Nevertheless, Ramsey presses his argument by insisting that equity requires Colonial Life to compensate him for monies that he would have spent on medical services had the group policy not been improperly canceled. He cannot be heard to do so now. We have indicated repeatedly that abandoned, waived, or forfeited issues may be reconsidered only when failure to do so would result in a miscarriage of justice.[15] Even though we are sympathetic to Ramsey's circumstances, we are satisfied that the instant appeal presents no such case. First, the district court's reading of the terms of the group policy is not unreasonable.[16] Second, that court specifically found that when Colonial Life denied Ramsey's coverage, it relied on genuine legal issues and did not act in bad faith.[17] We approved those findings in *Ramsey I*.[18] Accordingly, we can discern no need for a full reconsideration of the argument which Ramsey attempts to resurrect at this late stage in the case; and we hold therefore that the district

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effectively "ask[ed] the district court . . . to overturn this Court's dismissal of [the movant's] appeal"), *cert. denied*, 115 S. Ct. 1380 (1995); *Edward H. Bohlin Co. Inc. v. Banning Co.*, 6 F.3d 350, 353 (5th Cir. 1993) (emphasizing that Rule 60(b) motions are "not to be used as a substitute for appeal") (quoting *Seven Elves v. Eskenazi*, 635 F.2d 396, 401 (5th Cir. 1981)).

[15] *See, e.g., Batiansila v. Advanced Cardiovascular Sys., Inc.*, 952 F.2d 893, 896 (5th Cir. 1992).

[16] *See supra* note 3.

[17] *See Ramsey*, 843 F. Supp. at 1112.

[18] *See Ramsey I*, 12 F.3d at 480 (holding that district court's findings "are not so erroneous as to represent an abuse of discretion").

court properly denied Ramsey's motion for further relief.[19]

AFFIRMED.

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[19] Ramsey raises one additional argument in his reply brief, in which he challenges for the first time the district court's determination that he has not properly documented an amount allegedly owed by Colonial Life to the Mississippi Department of Rehabilitation Services for its provision of medical services to him. We have repeatedly held that we will not consider issues raised for the first time in a reply brief. *See, e.g., Glover v. Hargett*, 56 F.3d 682, 685 n.4 (5th Cir. 1995), *cert. denied*, 116 S. Ct. 726 (1996); *United States v. Jackson*, 50 F.3d 1335, 1340 n.7 (5th Cir. 1995); *Cavallini v. State Farm Mut. Auto Ins. Co.*, 44 F.3d 256, 260 n.9 (5th Cir. 1995).

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
SOUTHERN DIVISION

WILLIAM A. RAMSEY, JR. PLAINTIFF

VS. CIVIL ACTION NO. J90-0452 BN

THE COLONIAL LIFE INSURANCE COMPANY OF AMERICA, d/b/a CHUBB LIFEAMERICA DEFENDANT

ORDER

(Filed May 9, 1995)

The Court has before it the Motion of Plaintiff to Quantify Prior Judgement. On June 8, 1992, this Court entered its Memorandum Opinion and Order in which it ruled that the Plaintiff had continuing coverage under the policy in question for benefits up to the policy limits or until certain things occurred, none of which have or are likely so to do. That judgement was appealed and was affirmed by the appeals court.

Plaintiff was terribly injured and is now a permanent quadriplegic. He claims that he needs nursing care on a continual basis sixteen hours a day. He says his family can care for him the other hours. Since the filing of this lawsuit in 1992, Defendant has paid for a small amount of nursing care and for a wheelchair. This was done after the affirmance of the judgement by the appeals court. Plaintiff claims that he is entitled to recover for over $300,000 of nursing care that he would have incurred after Defendant denied further coverage and up to the present time. Plaintiff argues that but for Defendant's taking advantage of him, he would have had the nursing care that he

needed and that his family would not have had to provide those services. He in essence argues that it is not fair for the insurance company to take advantage of him when it would have had to pay had Plaintiff had the resources to pay in advance for the services he needed.

Defendant argues that this is a claims incurred policy and that it does not owe until Plaintiff has spent his money for the services that he claims he needs.

This Court held a status conference on February 14, 1995, in which it stated:

> The issue presented to the Court is whether the Plaintiff is entitled to recover under the policy of insurance for medical and other expenses which would otherwise have been covered by the policy and paid by the Defendant had the Defendant not wrongly cancelled the policy where the Plaintiff asserts that he would have incurred those expenses had the Defendant not cancelled the policy, but where the Plaintiff did not actually incur the expenses. Further, the Court is asked to determine the amount of those expenses and to award the Plaintiff a judgement in that amount.
>
> It appears to the Court, after the conference with the attorneys, that the most efficient manner of disposing of this Motion will be to bifurcate the legal issue of liability from the amount of damages and to hear the proof on damages only if the Plaintiff is successful on the liability issue on briefs and affidavits.

February 14, 1995, Order.

Plaintiff's position is summarized in these two sentences from his Supplemental Memorandum Brief Re: Declaratory Relief.

> The point here is, Chubb's conduct since the Fifth Circuit ruled against it in January 1994 by refusing to pay Mr. Ramsey has been outrageous and beyond all possible bounds of decency, atrocious, and utterly intolerable in a civilized community, and depends on nothing in ERISA. This Court is therefor urged to expand Mr. Ramsey's prayer for relief beyond mere attorney's fees to consider whether actual and punitive damages should be imposed against Chubb. . . .

Pl.'s Supp. Br. at 8. Plaintiff seeks relief of an equitable nature to do for him what ERISA does not otherwise allow, to grant him punitive damages for what he wrongly perceives to be an injustice.

This Court has already ruled on the basic issue presented by Plaintiff's Motion.

> Accordingly, the policy, by its very terms, provides that a specific medical care or service must be "rendered" before a benefit may be received under the policy. The Court therefore finds that no genuine issue of material fact exists as to Ramsey's claim for benefits under these provisions of the policy and that Defendant is entitled to judgment on this issue as a matter of law.

June 8, 1992, Mem. Op. and Order at 13. It makes no difference under the terms of this policy whether Mr. Ramsey had the resources to pay for needed nursing services in advance or not. Until such services were incurred, he could not claim reimbursement for them under the policy. Although harsh under the particular

circumstances of this case, the terms of this policy are nothing unusual. The medical care provider in the usual case is willing to advance the services on credit upon checking that there is in fact insurance coverage. Here, because of the contest over coverage, Plaintiff was unable to obtain such credit.[1]

Had this not been a case under ERISA, Plaintiff had his bad faith failure to pay claim under state law. But, ERISA does not allow the recovery of punitive damages. Also, Defendant had an arguable reason for its denial of coverage and the bad faith claim would not have been allowed even in state court.

Plaintiff finally argues that this Court should award him the monetary relief he wants under that part of 29 U.S.C. Sec. 1132(a)(3) which states:

> **(a) Persons empowered to bring a civil action**
>
> A civil action may be brought –
>
> . . . .
>
> (3) by a participant, beneficiary or fiduciary . . . (B) to obtain other appropriate equitable relief. . . .

But, the United States Supreme Court has specifically ruled that an award of monetary damages cannot be

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[1] The Defendant has given the Plaintiff a letter advising him that it will pay for nursing services of eight hours a day, but Plaintiff has not submitted a claim for any such services and claims he is entitled to services for sixteen hours a day. The Court does not have before it this controversy.

made under this section. See *Mertens v. Hewitt Associates*, ___ U.S. ___, 113 S. Ct. 2063, 124 L.Ed. 2d 161 (1993).

Plaintiff has no valid grounds on which to base his claim for relief and his Motion to Quantify Prior Judgement is therefore **DENIED**.

SO ORDERED this the 9th day of May, 1995.

/s/ William H. Barbour, Jr.
CHIEF JUDGE

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
JACKSON DIVISION

WILLIAM A. RAMSEY, JR. PLAINTIFF

VS. CIVIL ACTION NO. 3:90cv452BN

THE COLONIAL LIFE INSURANCE COMPANY OF AMERICA, d/b/a CHUBB LIFEAMERICA DEFENDANT

ORDER

(Filed Jul. 28, 1995)

This case is before the Court on the Motion of the Plaintiff for Reconsideration of Order entered May 9, 1995. The Court has considered the Motion, the Response of the Defendant thereto, Plaintiff's Rebuttal with Exhibit A attached thereto, and the Affidavit of Perry Winegarden submitted by the Plaintiff. The Court also heard arguments during a telephone conference conducted on July 27, 1995. The Court.finds that the Motion to Reconsider is not well taken and is denied.

The Order of the Court which the Plaintiff seeks to have reconsidered was entered at the conclusion of the liability phase of the trial which had been bifurcated from the damages phase. In that Order the Court ruled that the Plaintiff had continuing coverage under the policy but that the Defendant did not owe Plaintiff because the Plaintiff had not actually incurred any expenses covered by the policy. There was proof to the effect that the Mississippi Department of Rehabilitation Services had expended funds on behalf of Plaintiff. The Mississippi Department of Rehabilitation Services is not a party to

this case although it appears that the Department has a lien on any recovery that might be made by the Plaintiff under the insurance policy in question in this case. That policy requires the Plaintiff to file a Proof of Claim Form with the Defendant as a prerequisite to the payment of any claim. That has not been done. Accordingly, Plaintiff has not properly claimed the amount submitted by him in his attachments to and submissions with his Motion to Reconsider. Since the Motion seeks a judgement for those amounts, the Court finds that the Motion is not well taken and should be denied. This denial is not meant to act as an adjudication as to whether the amounts claimed by Plaintiff in his Motion to Reconsider are or are not payable under the policy to either the Plaintiff or to the Mississippi Department of Rehabilitation Services.

SO ORDERED this the 28th day of July, 1995.

/s/ William H. Barbour, Jr.
CHIEF JUDGE

William A. RAMSEY, Jr., et al., Plaintiffs,

William A. Ramsey, Jr., Plaintiff-Appellant Cross-Appellee,

v.

The COLONIAL LIFE INSURANCE COMPANY OF AMERICA, d/b/a Chubb Life America, Defendant-Appellee Cross-Appellant.

No. 92-7531.

United States Court of Appeals, Fifth Circuit.

Jan. 27, 1994.

Insured dependent under ERISA health insurance policy brought suit in state court seeking continuing coverage after employer terminated policy. Case was removed to federal court. The United States District Court for the Southern District of Mississippi, William Henry Barbour, Jr., Chief Judge, granted summary judgment in favor of insured dependent, but declined to award attorney's fees under ERISA and denied insured dependent's motion for reconsideration regarding fees. Dependent appealed, and insurer cross-appealed. The Court of Appeals, Goldberg, Circuit Judge, held that: (1) request to reconsider denial of attorney's fees was motion to alter or amend judgment, which tolled 30-day time limit for appealing district court judgment; (2) clause in policy limiting extension of benefits after policy termination to "12 months from date you became disabled" did not apply to dependent of insured employee, given distinctions made elsewhere in policy between insured, who

was referred to as "you" and dependents; (3) mutual mistake about scope of coverage afforded by original policy entitled dependent to avoid conversion policy and to receive premiums paid on that policy; and (4) district court did not abuse its discretion in denying attorney's fees to dependent.

Affirmed.

Appeal from the United States District Court for the Southern District of Mississippi.

Before GOLDBERG, HIGGINBOTHAM and DAVIS, Circuit Judges.

GOLDBERG, Circuit Judge:

This case comes to us as a claim for benefits by William Ramsey Jr. ("Ramsey"), under a medical insurance policy terminated by The Colonial Life Insurance Company of America ("Colonial Life"). When Ramsey became paralyzed from the neck down, he was covered as a dependent on a policy issued to his wife's employer, the Moulden Supply Company ("Moulden"). After two and one half years of paying Ramsey's medical bills, Colonial Life refused to continue covering Ramsey under the policy.

Ramsey filed suit and the court below took jurisdiction under the pre-emptive sweep of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. Sec. 1001, *et seq.; see Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 57, 107 S.Ct. 1549, 1558, 95 L.Ed.2d 39 (1987)

(claims for employee benefits predicated on state law are pre-empted by ERISA). The district court granted summary judgment in favor of Ramsey and ordered Colonial Life to continue covering Ramsey's medical expenses. The court also determined that Ramsey was not entitled to attorney's fees as provided in ERISA under 11 U.S.C. Sec. 1132(g)(1) and entered judgment accordingly.

Ramsey moved for reconsideration of the judgment to the extent that it denied attorney's fees. After his motion to reconsider was denied by the district court, Ramsey noticed an appeal to this court. Colonial Life subsequently cross-appealed the lower court's judgment as to Colonial Life's continued liability under the policy.

Addressing first the issue of Colonial Life's liability, Colonial Life asserts that Ramsey was covered under an expense policy which pays benefits only while premiums are being paid by the policyholder. According to Colonial Life, once the premiums stop, the coverage terminates. The company distinguishes Ramsey's expense policy from an accident policy, in which a beneficiary is insured for the duration of any injury suffered while the policy is in force. This form of insurance covers medical expenses incurred after the policy is canceled as long as the injury was suffered while the policyholder was paying the premiums.

Colonial Life contends that the unfortunate but indisputable result of Ramsey's limited form of coverage was that when his wife's employer canceled the policy, Ramsey's benefits were terminated. According to Colonial Life, these shortcomings were intrinsic to Moulden's policy. Colonial Life thus argues that, although seemingly

inappropriate, the termination of benefits was in compliance with the substance of Ramsey's insurance coverage.

We decline to follow the interpretation of the insurance contract urged by Colonial Life, however, for the simple reason that a facial reading of the contract reveals that Ramsey's benefits extend beyond termination of the policy. The unfortunate result of the plain meaning of the contract is that the insurance company will bear the continuing burden of compensating Ramsey for medical expenses without the benefit of continued premium payments. However, the insurance policy was formulated by Colonial Life itself and therefore Colonial Life cannot contest being bound to its own contract. We find the district court's result is correct and we affirm.

I. Facts

The relevant facts in this case are not in dispute. The insurance policy in question was acquired by Moulden Supply Company, Inc. in August of 1986 from defendant Colonial Life. Dianne Ramsey, an employee of Moulden, chose to cover herself and all her dependents, including her husband, Ramsey, under Moulden's group policy.

On January 31st, 1987, Ramsey fell off a ladder and fractured his spine while working in his yard. The resulting quadriplegia permanently and totally disabled him to the point where he will require medical treatment and care for the remainder of his life.

After incurring the additional expenses which resulted from covering Ramsey's condition, Colonial Life

dramatically escalated Moulden's premiums.[1] On August 1, 1989, as a consequence of the severity of the premium increase, Moulden Supply canceled the policy.

The insurance policy was an expense policy, as described above, which discontinued the insured's rights to receive reimbursement for medical expenses at the time the policyholders terminated the policy.[2] Due to the immanent [sic] loss of coverage, Ramsey and his wife sought to secure a conversion policy from Colonial Life that would afford the same benefit level as had been provided under the Moulden group policy. Colonial Life issued a conversion policy to the Ramseys with a strict $20,000 maximum lifetime limit on benefits, significantly lower than the $2,000,000 limit that the old Moulden group policy provided. Ramsey, despite the reduction in coverage, paid the required premiums on the conversion policy.

At the end of July, 1990, Colonial Life began refusing to pay any further medical expenses incurred by Ramsey. On August 9, 1990, Ramsey and his wife filed a lawsuit against Colonial Life in the state Circuit Court of Hinds County, Mississippi, alleging state law claims of bad faith refusal to pay benefits and gross negligence with intent to

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[1] There are allegations in the record that an additional factor in the premium increase was a heart condition of another Moulden group policy participant.

[2] The problems presented in this case are only a microcosm of the global failures of our present day health care system. While the daunting task of overhauling the administration of health care falls to the President and Congress, in this case our role is more manageable: deciding the extent of coverage maintained for the benefit of a single individual.

deceive in inducing plaintiffs to convert to a policy with substantially lower limits.

Colonial Life subsequently removed the action to the United States District Court for the Southern District of Mississippi. Judge William H. Barbour Jr. recharacterized the pleadings as a claim for benefits under the provisions of ERISA, 29 U.S.C. Sec. 1132(a)(1)(B) providing a federal cause of action to obtain entitlements due under employee benefits plans. *See Degan v. Ford Motor Co.*, 869 F.2d 889 (5th Cir.1989).

Under the reconstituted pleadings, Judge Barbour dismissed Ramsey's wife and various state law causes of action. The district court framed the remaining issues as follows: (1) whether Ramsey was entitled to benefits under the original Moulden group policy, (2) whether he had any rights under the conversion policy, and (3) whether he could recover attorney's fees. During the pendency of the federal litigation, Colonial Life tendered payment for medical expenses incurred by Ramsey during the first twelve months following the group policy cancellation.

As to the first issue, the district court ruled that under ERISA, the issues presented should be answered by referencing the body of federal common law. *See In re Heci Exploration Co., Inc.*, 862 F.2d 513, 521 (5th Cir.1988). Under federal common law, the court ruled that Ramsey was entitled to continuing coverage based upon the court's interpretation of the Extension of Medical Benefits section of the policy. The court began its analysis by noting that the Termination of Insurance section of the

policy states that "some medical benefits may be continued" after termination of the policy. The opinion then refers to the section of the policy entitled "Extension of Medical Benefits" which reads:

> If you or a dependent are totally disabled when premium payments stop, medical benefits will be continued, until the earlier of:
>
> a. 12 months from the day you become disabled;
>
> b. the date total and continuous disability ends;
>
> c. you or the dependent are insured for similar medical benefits under another group plan. The plan must pay benefits for the injury or sickness that caused the total disability.

Judge Barbour reasoned that this section is internally inconsistent because on the one hand it mandates extension of coverage, "medical benefits will be continued," but, on the other hand, subsection a. denies Ramsey the extension of benefits because he was disabled more than twelve months prior to termination of the policy. The court determined that the clause mandating extension expressed the authentic intent of the policy and Judge Barbour thus nullified subsection a. as it applied to Ramsey. The court held that Ramsey was entitled to an extension of benefits until his disability came to an end, or until he obtained other insurance.

The judge also ruled that any premiums paid under the conversion policy were unnecessary and should be refunded. As to attorney's fees, Judge Barbour held that because there was no showing of a bad faith denial of

benefits by Colonial Life, there should be no award of attorney's fees.[3] *See Pitts v. American Security Life Insurance Co.*, 931 F.2d 351, 358 (5th Cir.1991) (setting out the five factor test for awarding attorney's fees). Judge Barbour also referenced various other considerations which militated for the denial of attorney's fees.

The district court entered its final judgment on June 9, 1992 including a denial of attorney's fees. Ramsey moved for reconsideration of the attorney's fee ruling on June 23. The district court denied this motion on July 17, and Ramsey proceeded to file his notice of appeal on August 11. Colonial Life then cross-appealed on the issue of the district court's extension of Ramsey's insurance coverage.

Before advancing to our discussion of the merits of this appeal, we must first address the question of whether the notice of appeal was timely filed.

II. Analysis

A. Timeliness of Appeal

We must determine whether Ramsey's appeal was properly filed within the thirty day limit as required by Federal Rule of Appellate Procedure (FRAP) 4(a)(1).[4] We

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[3] The request for attorney's fees was made under the appropriate provision in ERISA, 29 U.S.C. 1132(g)(1).

[4] FRAP 4(a)(1) provides:

> In a civil case in which an appeal is permitted by law as of right from a district court to a court of appeals the notice of appeal required by Rule 3 shall be filed with the clerk of the district court within 30

address the issue of timeliness as an initial matter because the "time limits for filing a notice of appeal are 'mandatory and jurisdictional' " *First Nationwide Bank v. Summer House Joint Venture*, 902 F.2d 1197, 1199 (5th Cir.1990) (quoting *Budinich v. Becton Dickinson and Co.*, 486 U.S. 196, 203, 108 S.Ct. 1717, 1722, 100 L.Ed.2d 178 (1988)).

In this case, a final judgment including a denial of attorney's fees, was entered on June 9, 1992. The notice of appeal was filed on August 11, two months later, well beyond the thirty day limit of Rule 4(a)(1). Nevertheless, both parties agree that the appeal should be considered timely because Ramsey moved for reconsideration of the attorney's fee ruling on June 23; an action which they argue should have tolled the thirty day limit. They claim that Ramsey's motion was a Federal Rule of Civil Procedure 59(e) motion which, under FRAP 4(a)(4)[5], alters the timeliness requirements for filing appeals. The parties contend that since the appeal was filed within thirty days of the decision to deny Ramsey's motion to reconsider, it was timely filed. On review, we agree with their contentions.

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days after the date of entry of the judgment or order appealed from.

[5] FRAP 4(a)(4) provides:

> If a timely motion under the Federal Rules of Civil Procedure is filed in the district court by any party . . . under Rule 59 to alter or amend the judgment . . . the time for appeal for all parties shall run from the entry of the order denying a new trial or granting or denying any other such motion.

The difficulty with the parties' position arises out of the Supreme Court's decision in *Budinich*, 486 U.S. 196, 108 S.Ct. 1717, 100 L.Ed.2d 178. In that case, the Court announced that a request for attorney's fees will not prevent an otherwise final decision on the merits from becoming final for purposes of timely appeal. 486 U.S. at 202, 108 S.Ct. at 1722.

The *Budinich* opinion relies heavily on *White v. New Hampshire Dept. of Employment Security*, 455 U.S. 445, 102 S.Ct. 1162, 71 L.Ed.2d 325 (1982), which set out the principle that a request for attorney's fees was not a Rule 59(e) motion. *See also Knighton v. Watkins*, 616 F.2d 795, 797 (5th Cir.1980) ("a motion for attorney's fees is unlike a motion to alter or amend a judgment . . . [and so] is, therefore, not governed by the provisions of 59(e)"). The Court in *White* reasoned that a request for attorney's fees is a collateral issue akin to a motion for costs that does not amend or alter a judgment on the merits. In addition, the Court sought to avoid the "harsh and unintended consequences" of applying the narrow ten day time constraints of Rule 59(e) to the ameliorative intent of the attorney's fee shifting provision of 42 U.S.C. Sec. 1988. *White*, 455 U.S. at 452, 102 S.Ct. at 1167.

We believe that the motion to reconsider attorney's fees under consideration here is distinguishable from both *White* and *Budinich* because the motion, unlike the cases presented to the Supreme Court, is not an original request for attorney's fees. Instead we have a case in which the district court, as part of its final judgment on the merits, has already passed on and denied the plaintiff's motion for attorney's fees. Thus, plaintiff's motion was not an original request for fees but instead was a

motion for reconsideration of a final judgment where the subject matter of that motion happened to focus on the question of attorney's fees.[6]

In *Charles v. Daley*, 799 F.2d 343, 347 (7th Cir.1986) the Seventh Circuit, in an analogous situation, ruled that a request to clarify the court's order with regard to attorney's fees and to alter the parties responsible for those fees was considered a Rule 59(e) motion which effectively tolled the thirty day time limitation for filing appeals. The *Charles* court cited with approval our decision in *Harcon Barge Co. v. D & G Boat Rentals, Inc.*, 784 F.2d 665 (5th Cir.1986) (en banc), *cert. denied*, 479 U.S. 930, 107 S.Ct. 398, 93 L.Ed.2d 351, in which we held that a "motion that 'calls into question the correctness of a judgment should be treated as a motion under Rule 59(e), however it is styled.' " 784 F.2d at 670 (quoting *Dove v. Codesco*, 569 F.2d 807, 809 (4th Cir.1978)).

The motion in this case was filed within the ten day limit of Rule 59(e) and requested reconsideration of an issue determined in the final judgment. In a case where attorney's fees are one part of an integrated judgment on the merits, this court has treated a motion to reconsider the judgment which includes reconsideration of the attorney's fees issues to be pursuant to Rule 59(e). *See Treuter*

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[6] This result comports with the basic remedial purpose behind attorney's fees statutes generally. *See White*, 455 U.S. at 452, 102 S.Ct. at 1167. To penalize a litigant for seeking attorney's fees by refusing to toll the thirty day limitation would put them at a disadvantage as compared to those litigants who were moving to have a judgment reconsidered based on other grounds.

v. Kaufman County, Texas, 864 F.2d 1139 (5th Cir.1989) (motion to reconsider order which included attorney's fees adjudication constituted Rule 59(e) motion). In the instant case, we have a motion to reconsider which solely implicates the attorney's fees portion of the judgment. We see no reason to distinguish this motion to reconsider merely because it exclusively addresses the attorney's fees portion of the judgment. One notices appeals of judgments, not issues. Thus, a Rule 59 motion to reconsider a judgment should stay appeals of all issues decided by that judgment.

Admittedly, a line of cases has arisen to complicate our analysis. This court, in *Echols v. Parker,* 909 F.2d 795 (5th Cir.1990) ruled that a supplemental motion for attorney's fees filed after the court had already addressed the issue would, like original requests for fees, not be considered a Rule 59(e) motion. The *Echols* court stated that "Rule 59(e) does not apply to a motion for attorney's fees under 42 U.S.C. Sec. 1988, whether the motion is original or supplemental." 909 F.2d at 799 (quoting *Cruz v. Hauck,* 762 F.2d 1230, 1236 (5th Cir.1985)); *accord Campbell v. Bowlin* 724 F.2d 484 (5th Cir.1984) (motion to supplement attorney's fees not cognizable under Rule 59(e)); *Cobb v. Miller,* 818 F.2d 1227 (5th Cir.1987) (where judgment on merits includes disposition of attorney's fees, motion to request additional fees incurred on appeal remains a collateral issue not governed by Rule 59(e)).

The focus of our concern becomes how broad a definition should be given to the term "supplemental" motion. In all these decisions, similar to the situation before us in the instant case, the district court disposed of the issue of attorney's fees in its judgment on the merits.

What distinguishes these other cases from the situation under consideration here is that the litigant's motion in these other cases was a request for additional fees. *See e.g. Echols*, 909 F.2d at 798. The term supplement itself implies that the movant is seeking merely to add to an original request.

By contrast, in the instant case Ramsey asked the lower court to amend the final judgment issued by the court. That is, he made a motion requesting that the judge reconsider his decision denying altogether any grant of attorney's fees. The relevant distinction is that the *Echols* line of cases presents requests for additional fees, a situation almost identical to *Budinich* which involved an original request for fees. In the instant case, Ramsey does not request additional fees, he requests only that the judge review his decision denying fees in the first place. *Echols* is therefore not relevant to our holding as it merely stands for the proposition that a request for fees, whenever it is made, is not considered a Rule 59(e) motion.

Today we rule that a motion to reconsider a judgment will be considered a Rule 59(e) motion even where the request for reconsideration encompasses only that part of the judgment regarding attorney's fees. Because Ramsey's request to reconsider the denial of attorney's fees was a Rule 59(e) motion, under Federal Rule of Appellate Procedure 4(a)(4), this motion tolled the thirty day time limit for appealing a district court judgment until the judge disposed of the motion. In sum, Ramsey's notice of appeal, filed within thirty days of the judge's denial of his Rule 59(e) motion, was timely and we are now able to proceed to the merits of his appeal.

B. Extension of the Group Policy Benefits

Colonial Life, in its cross-appeal, disputes the interpretation of the insurance policy given by Judge Barbour requiring the extension of medical coverage for Ramsey. Our first task in evaluating this contention is to determine the appropriate level of review.

For this endeavor, we turn to *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989) where the Supreme Court laid out a scheme for determining the standard of review in ERISA litigation. The reviewing court, in entertaining a claim which questions, "a denial of benefits . . . under Sec. 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Bruch*, 489 U.S. at 115, 109 S.Ct. at 956-7; *Schultz v. Metropolitan Life Ins. Co.*, 872 F.2d 676, 678 (5th Cir.1989) (where "[n]either party has pointed to any provision in the Plan which gives the administrator discretionary authority to determine benefit eligibility or to construe the plan terms . . . the district court's review of the administrator's denial of the [plaintiff's] claim will be tested here based on a de novo review standard."); *Wise v. El Paso Natural Gas Co.*, 986 F.2d 929, 934 (5th Cir.1993) (same). There has been no allegation that Colonial Life exercised its discretionary authority in denying Ramsey's benefits. We are therefore required to invoke a de novo evaluation of Colonial Life's decision to terminate Ramsey's coverage.

The district court ordered Colonial Life to continue Ramsey's medical coverage under the provisions of the

extension of benefits clause. We need not evaluate the analysis propounded by Judge Barbour ignoring the subsection a. time limit based on a contradiction within the policy which he understands to mandate an extension of benefits. Instead, we hold that the language of section a. is inapplicable to Ramsey by its very terms and therefore we require Colonial Life to offer Ramsey an extension of his insurance benefits under the old policy.

The insurance policy in question commences with the following introductory definition, " 'You' or 'yours' refers to the employee, not the policyholder." While the policy is not at this point clear whether "you" or "yours" includes dependents of the employee, a comprehensive look at the policy reveals a consistent differentiation between "you" and "your dependents". For instance, the policy describes when "[y]our insurance will end" and when "[d]ependents insurance will end" as separate eventualities. The termination of the employee's insurance by definition terminates the dependent's insurance.

Recapitulating the text of the relevant Extension of Medical Benefits section, the opening sentence states that "[i]f you or a dependent are totally disabled . . . medical benefits will be continued, until the earlier of," followed by three possible conditions. The distinction between the employee and his or her dependents is thus maintained in the initial clause of the relevant section.

The most pertinent condition to the extension of benefits is set out in the following subsection which plainly states that the benefits will continue until, "a. 12 months from the day *you* become disabled." (emphasis added). It is this section which Colonial claims precludes Ramsey

from receiving continuing coverage as he was disabled more than twelve months prior to the termination. However, the clear language of this condition does not include dependents of the employee. The section is directed only at the employee him or herself. It therefore cannot be applied to Ramsey as a dependent.

By contrast, the third condition of the very same extension clause, subsection c., states just as plainly that benefits will continue until, "c. you *or the dependent* are insured for similar medical benefits under another group plan." (emphasis added). Had Colonial Life intended subsection a. to cover Ramsey, it should have written it to mirror subsection c. In that case subsection a. would read, "12 months from the day *you or your dependents* become disabled." Because it did not, the subsection is not relevant here and will not terminate Ramsey's extension of benefits.

While this reading seems to elevate the picayune to the preposterous, we note that the language of these sections is absolutely clear: the section in the policy as a whole, and this clause in particular, continuously refer to "you or the dependent" while the clause limiting the extension to twelve months names only "you". The intent of the drafters which arises from the plain wording of this sentence is pellucid in its simplicity: section a. does not apply to dependents, i.e. Ramsey.

Even if the policy was not entirely consistent in distinguishing between the employee and his or her dependents, the precise reference in this particular section would be, at best, ambiguous. We cognize that this circuit

follows the *contra proferentem* rule of contract interpretation in the ERISA context. *Hansen v. Continental Ins. Co.*, 940 F.2d 971 (5th Cir.1991); *cf. Wise*, 986 F.2d 929, 938 (rule of contract interpretation "mandate[s] that we adopt the most pro-beneficiary interpretation"). This rule has been adopted by various circuits. *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534 (9th Cir.1990) (*cert. denied* 498 U.S. 1013, 111 S.Ct. 581, 112 L.Ed.2d 587) (rule of *contra proferentem* applies); *McNeilly v. Bankers United Life Assurance Co.*, 999 F.2d 1199, 1201 (7th Cir.1993) ("when plan terms are ambiguous, we construe them strictly in favor of the insured."); *Delk v. Durham Life Ins. Co.*, 959 F.2d 104 (8th Cir.1992) (adopting the contra insurer rule when the language remains ambiguous even when accorded its ordinary meaning).

In *Hansen* we wrote that "[a]ny burden of uncertainty created by careless or inaccurate drafting of the summary must be placed on those who do the drafting, and who are most able to bear that burden, and not on the individual employee, who is powerless to affect the drafting of the summary or the policy and ill equipped to bear the financial hardship that might result from a misleading or confusing document." 940 F.2d at 982. In the instant case, we construe any confusion which may arise as to the ambiguous reference of "you" in subsection a. against the insurer and presume that it refers only to the employee and not his or her dependents.

Simple rules of contract interpretation demonstrate that the clause limiting the extension of benefits to "12 months from the day you became disabled" does not apply to Ramsey. The extension of benefits granted to Ramsey should continue until either of the other two

conditions set out in subsections b. and c. of the extension of benefits clause come to pass or until he reaches the policy limits. Thus, we hold that the district judge reached the correct result when he determined that Ramsey was entitled to continued medical coverage under the policy until such time as he finds other insurance, he is no longer paralyzed, or until the policy limit of $2,000,000 has been reached.

C. Conversion Policy

We also follow Judge Barbour's ruling on the conversion coverage. The conversion policy was written to cover Ramsey from the time his wife's group policy at Colonial Life terminated. Because we agree that the original coverage continues to provide protection, there was no reason for Ramsey to have purchased a conversion policy and the district court properly entered judgment in favor of plaintiff in the amount Ramsey paid for that policy.

Where both parties to a contract are mistaken as to a material aspect of the contract, a court can reform or void the parties' obligations under that document. *See Audio Fidelity Corp. v. Pension Ben. Guaranty Corporation*, 624 F.2d 513, 518 (4th Cir.1980) (in interpreting an ERISA-governed pension, "a court of equity can reform a contract to correct a mistake. . . . But the mistake must be mutual."); *cf. Meza v. General Battery Corp.*, 908 F.2d 1262 (5th Cir.1990) (mutual mistake allows reformation of collective bargaining agreement). Because both parties would not have agreed to the contract had they known the proper construction of the group policy, a mutual mistake about the scope of coverage, the disadvantaged

party is entitled to avoid the contract. *Audio Fidelity,* 624 F.2d at 518. We conclude that the district court properly ordered Colonial Life to refund all payments made by Ramsey in support of the conversion policy.

D. Attorney's Fees

Ramsey complains that the district court's erred in denying his request for attorney's fees. The denial was based on an evaluation of the five factor test set out in *Pitts,* 931 F.2d at 358 (*quoting Ironworkers Local No. 272 v. Bowen,* 624 F.2d 1255, 1266 (5th Cir.1980)).[7]

Our review is limited to an abuse of discretion inquiry. 29 U.S.C. Sec. 1132(g); *Pitts,* 931 F.2d at 358. In his decision, Judge Barbour reviewed the application of the *Pitts* test to the facts of this case and found that Ramsey was not entitled to attorneys fees for a variety of reasons. The district court established that Colonial Life had not acted in bad faith and had genuine legal issues upon which to base their denial of coverage. The court also found that while Colonial Life could afford to pay the attorney's fees award, the uniqueness of the circumstances greatly diminished the deterrent effect of the

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[7] The five factor test is as follows: "(1) the degree of the opposing party's culpability or bad faith, (2) the ability of the opposing party to satisfy an award of attorney's fees, (3) whether an award of attorney's fees would deter other persons who will be acting under similar circumstances, (4) whether the party seeking attorney's fees sought to benefit all participants in an ERISA plan or to resolve a significant legal question under ERISA, and (5) the relative merits of the parties positions." *Pitts,* 931 F.2d at 358.

ruling and the Ramsey's suit had no applicability to other ERISA participants. Because we cannot say these findings are so erroneous to represent an abuse of discretion, we affirm the denial of attorney's fees.

III. Conclusion

The judgment of the district court is AFFIRMED.

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
JACKSON DIVISION

WILLIAM A. RAMSEY, JR. PLAINTIFF

VS. CIVIL ACTION NO. J90-0452BN

THE COLONIAL LIFE INSURANCE COMPANY OF AMERICA, d/b/a CHUBB LIFEAMERICA DEFENDANT

ORDER

(Filed Oct. 28, 1994)

Before the Court is the Plaintiff's Motion to Quantify Prior Judgment and for Declaratory Relief. The Plaintiff, William Ramsey ("Ramsey") asks the Court "to quantify and declare the precise amount that the Defendant is indebted to plaintiff" as of September 20, 1994, pursuant to the Final Judgment entered by the Court in this case on June 8, 1992. The Defendant, Colonial Life Insurance Company ("Colonial Life"), has responded to the Motion, and argues primarily that this Court does not have subject matter jurisdiction to hear the case. Having considered the Motion and response, the Court finds it has jurisdiction to decide Ramsey's Motion, and orders both parties to confer and contact the Court Deputy to set an evidentiary hearing on this matter.

I. DISCUSSION

Colonial Life argues that Ramsey's Motion is "untimely," since this Court entered its final judgment over two years ago, and since the United States Court of Appeals for the Fifth Circuit affirmed that decision in

January 1994.[1] Colonial Life argues further that the relief Ramsey seeks, that the Court quantify and declare the precise amount that Colonial Life is indebted to Ramsey, is authorized neither by the 1992 Order of this Court, nor by the Federal Rules of Civil Procedure. Underlying both these arguments is the contention of Colonial Life that this Court lacks jurisdiction to hear the present Motion. The Court disagrees.

In the cause of action originally before this Court, part of the relief which Ramsey requested and which this Court granted, was that of a declaratory judgment. *See* Mem. Op. and Order of June 9, 1992, at 4 ("By way of relief, Plaintiffs asked for a declaratory judgment that the group policy was still in force and effect as to claims related to Mr. Ramsey's quadriplegia up to the maximum limit of $2,000,000."). In that case the Court entered judgment "in favor of Plaintiff William A. Ramsey, Jr., . . . declaring that, pursuant to the extension of benefits clause of Group Policy No. 330197, William A. Ramsey, Jr., is entitled to continued medical coverage. . . . " Final J. at 1.

The Court has jurisdiction over Plaintiff's Motion pursuant to 28 U.S.C. § 2202, which expressly provides for "[f]urther necessary or proper relief based on a declaratory judgment or decree." Although the Court has not yet considered the merits of the Motion currently before it, the Court finds that this is an instance where it is "necessary or proper" to exercise jurisdiction under 28 U.S.C. § 2202. The Court agrees with the analysis of the District Court for the District of Columbia, in a case in

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[1] *Ramsey v. Colonial Life Ins. Co.*, 12 F.3d 472 (5th Cir. 1994).

which Amtrak sought additional action from the lower court after the court of appeals affirmed a declaratory judgment.

> Further relief, based on the original declaratory judgment, may be granted wherever it is either "necessary *or proper*." 28 U.S.C. § 2202 (emphasis added). Propriety is of course a broader concept than necessity. In consideration of this language, the requirement that a plea for further relief must be "based on" the declaratory judgment should be broadly read. [citation omitted]. . . . Amtrak's present claims for damages flow directly from the judgment of this Court. The Court finds it both proper and efficient for Amtrak to prosecute its claims in a petition for further relief. Having decided the action upon which Amtrak's petition is founded, the Court is familiar with the case. To force Amtrak to initiate a new lawsuit which might be heard by a different Court would be wasteful of judicial resources.

Horn & Hardart Co. v. National R.R. Passenger Corp., 659 F. Supp. 1258, 1262 (D.D.C. 1987), *aff'd*, 843 F.2d 546 (D.C. Cir. 1988), *cert. denied*, 480 U.S. 849. The reasoning of the Court in *Horn* (under circumstances procedurally similar to those before this Court) is sound. In the present case, nothing would be gained by forcing the Plaintiff to file another lawsuit, and perhaps face a judge unfamiliar with the case.

II. CONCLUSION

Colonial Life devotes most of its Response to the jurisdictional question, an issue which the Court herein

decides in the Plaintiff's favor.[2] So that it may determine if Ramsey is entitled to the relief he requests in his Motion, the Court directs both parties to confer and contact the Court Deputy no later than **November 3, 1994,** to set a date and time for an evidentiary hearing on the merits of the Plaintiff's Motion.

IT IS THEREFORE ORDERED that the Court has subject matter jurisdiction to hear the Motion of the Plaintiff William A. Ramsey.

IT IS FURTHER ORDERED that the Plaintiff William A. Ramsey and the Defendant Colonial Life Insurance Company confer and contact the Court Deputy no later than **November 3, 1994,** to set an evidentiary hearing on the merits of the Plaintiff's Motion.

SO ORDERED this the 27th day of October, 1994.

/s/ William H. Barbour, Jr.
CHIEF JUDGE

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[2] At page three of its Response, the Defendant writes, "[A]s Plaintiff did not file a brief setting forth any legal arguments supporting the 'Motion,' Colonial Life reserves further comment until such time as further response may be necessary or appropriate."

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
JACKSON DIVISION

WILLIAM A. RAMSEY, JR. PLAINTIFF

VS. CIVIL ACTION NO. 3:90-CV-0452BN

THE COLONIAL LIFE INSURANCE COMPANY OF AMERICA, d/b/a CHUBB LIFEAMERICA DEFENDANT

ORDER

(Filed Feb. 14, 1995)

The Court held a status conference on this day by telephone with James W. Nobles, Jr. and Pat M. Barrett, Jr. for the Plaintiff and Robert C. Boyd for the Defendant. There is presently pending the Motion of Plaintiff to Quantify Prior Judgement. At an earlier status conference, the parties announced that they thought they could reach a stipulation which would allow the Court to decide the Motion without a hearing, but they have been unable to do so. The Court accordingly finds and orders as follows.

The issue presented to the Court is whether the Plaintiff is entitled to recover under the policy of insurance for medical and other expenses which would otherwise have been covered by the policy and paid by the Defendant had the Defendant not wrongly cancelled the policy where the Plaintiff asserts that he would have incurred those expenses had the Defendant not cancelled the policy, but where the Plaintiff did not actually incur the expenses. Further, the Court is asked to determine the

amount of those expenses and to award the Plaintiff a judgement in that amount.

It appears to the Court, after the conference with the attorneys, that the most efficient manner of disposing of this Motion will be to bifurcate the legal issue of liability from the amount of damages and to hear the proof on damages only if the Plaintiff is successful on the liability issue. The attorneys have agreed that they can present the liability issue on briefs and affidavits.

IT IS THEREFORE SO ORDERED and the Plaintiff is given until March 6, 1995, to present its brief and any affidavits or other exhibits in support of his position on the liability issue. The Defendant is given until March 17, 1995, to respond with its brief and any affidavits or other exhibits in support of its position on the liability issue. The Plaintiff shall thereafter have until March 24, 1995, to present his rebuttal, if any. If the Court determines the liability issue in favor of the Plaintiff, it will thereafter set a hearing on the issue of damages.

SO ORDERED this the 14th day of February, 1995.

/s/ William H. Barbour, Jr.
CHIEF JUDGE

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
JACKSON DIVISION

WILLIAM A. RAMSEY, JR.
and DIANNE W. RAMSEY — PLAINTIFFS

VS. — CIVIL ACTION NO. J90-0452(B)

THE COLONIAL LIFE INSURANCE
COMPANY OF AMERICA d/b/a
CHUBB LIFEAMERICA — DEFENDANT

FINAL JUDGMENT

(Filed Jun. 9, 1992)

Consistent with the Memorandum Opinion and Order entered this day in the above styled cause, wherein plaintiffs' Motion for Summary Judgment was granted as to the issue of extension of benefits under Group policy No. 330197 and Defendants' Cross-Motion for Summary Judgment was granted as to all other claims asserted in the Complaint, Final Judgment is hereby entered.

IT IS THEREFORE ORDERED that Judgment be entered in favor of Plaintiff William A. Ramsey, Jr., and against Defendant Colonial Life Insurance Company of America d/b/a Chubb LifeAmerica declaring that, pursuant to the extension of benefits clause of Group Policy No. 330197, William A. Ramsey, Jr., is entitled to continued medical coverage under Group Policy No. 330197 as though it had never been cancelled by Mouldin Supply Company, Inc., for the condition of quadriplegia until such time as Mr. Ramsey's total and continuous disability ends, Mr. Ramsey is insured for similar medical benefits under another group plan, or the medical coverage limit

of $2,000,000.00 under Group Policy No. 330197 is exhausted, whichever occurs first.

IT IS FURTHER ORDERED that Judgment be entered in favor of Plaintiff William A. Ramsey, Jr., and against Defendant Colonial Life Insurance Company of America in the amount of $1,400.00, that amount representing premium payments previously made by Ramsey on a conversion policy issued by Defendant to Ramsey.

IT IS FURTHER ORDERED that plaintiffs William A. Ramsey, Jr., and Dianne W. Ramsey are not entitled to an award of attorney's fees in this action and that judgment be entered in favor of Defendant Colonial Life Insurance Company of America on such claim.

IT IS FURTHER ORDERED that Judgment be entered in favor of Defendant Colonial Life Insurance Company of America and against Plaintiffs William A. Ramsey, Jr., and Dianne W. Ramsey on all other claims asserted in this lawsuit and that all such claims be hereby dismissed with prejudice.

IT IS FURTHER ORDERED that costs be awarded in favor of Plaintiffs and against Defendant.

SO ORDERED this the 8th day of June, 1992.

/s/ William H. Barbour, Jr.
CHIEF JUDGE

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
JACKSON DIVISION

WILLIAM A. RAMSEY, JR.
and DIANNE W. RAMSEY — PLAINTIFFS

VS. — CIVIL ACTION NO. J90-0452(B)

THE COLONIAL LIFE INSURANCE
COMPANY OF AMERICA d/b/a
CHUBB LIFEAMERICA — DEFENDANT

MEMORANDUM OPINION AND ORDER

(Filed June 9, 1992)

This cause is before the Court, pursuant to Rule 56 of the Federal Rules of Civil Procedure, on Plaintiffs' Motion for Summary Judgment. Defendant has responded to the Motion and has filed a Cross-Motion for Summary Judgment. The Court, having considered the Motions and Responses, together with memoranda of authorities and attachments thereto, now renders the following findings of fact and conclusions of law.

I. FACTS AND PROCEDURAL HISTORY

In October of 1975, Plaintiff Dianne Ramsey began work for Moulden Supply Company, Inc. Dianne Ramsey left Moulden Supply in January of 1980 to work elsewhere, but returned to Moulden Supply as an employee in September of 1983. At the time of her return to Moulden Supply, Dianne Ramsey was offered group insurance coverage through her employer. Although the insurance carrier of the group policy at that time was not

Defendant Colonial Life Insurance Company of America, Moulden Supply did change its group policy to Colonial Life on August 1, 1986. At the time that the change to Colonial Life was made, Dianne Ramsey chose to cover herself, her spouse, Plaintiff William A. Ramsey, Jr., and her two children under Colonial Life Group Policy No. 330197. That policy provided a $2,000,000 maximum lifetime limit for medical expenses attributable to any one illness or accident.

On January 31, 1987, William Ramsey sustained a complete fracture of several vertebrae in his neck, resulting in permanent and irreversible quadriplegia. Subsequently, Colonial Life began to pay medical expenses for Mr. Ramsey pursuant to Group Policy No. 330197.

On or about June 23, 1989, Moulden Supply orally notified its employees that it was cancelling Group Policy No. 330197. By letter dated July 31, 1989, Moulden Supply formally notified Colonial Life of its termination of the group policy. By letter dated August 1, 1989, Moulden Supply formally notified its employees that the termination of the policy had become effective. At the time that the policy was terminated on August 1, 1989, Colonial Life had paid medical expenses for Mr. Ramsey in the approximate amount of $275,000.

Subsequent to the termination of Group Policy No. 330197, Dianne Ramsey contacted the Mississippi Department of Insurance andasked them to review the policy. By letter dated August 7, 1989, the Department of Insurance informed Mrs. Ramsey that the policy contained "no provision for continuation of coverage by extension of benefit or right to convert." Thereafter, on August 22, 1989,

Colonial Life informed the Department of Insurance that Mr. Ramsey was entitled under the policy to a twelve month extension of benefits for the condition of paralytic syndrome. The record does not reveal that the Ramseys were informed of the Colonial Life letter.

On the advice of counsel, Plaintiffs sought to secure a conversion policy from Colonial Life that would provide the same benefits as had been afforded under the group policy. Accordingly, Plaintiffs executed a medical conversion application on September 5, 1989, and enclosed a check to cover the first premium due under the conversion policy. By way of a letter from Plaintiffs' counsel enclosed with the conversion application, Colonial Life was advised that

> certain plan numbers and a maximum [$20,000] benefit are entered on the application form. These numbers were taken from the information printed on other pages of your application form as being the maximum benefits and coverage available. However, please consider that application is hereby being made for the same benefits and continuation of the basic level of coverage as provided to the Ramseys under policy number 330197, as required in the Fifth Circuit case of *Baker v. Washington National Insurance Company*, 823 F.2d 156 (1987). . . .

Although the record is unclear on this point, all parties agree that the conversion policy with its $20,000 maximum lifetime medical benefits limit went into effect sometime following the termination of the group policy. Claims for Mr. Ramsey's medical expenses were submitted to Colonial Life during the period following August 1, 1989, but no claims were paid. Specifically, with regard

to claims submitted during the twelve month period following the termination of the group policy, claims were denied by Colonial Life on the following basis:

> The policy does not allow benefits for services rendered after the group coverage terminates unless the patient was totally disabled from the date of termination. Since coverage terminated on 07/31/89 and the above services were rendered after that date, no benefits are payable.
>
> If disability exists, send us a doctor's statement and further consideration will be given. We suggest that you contact your employer concerning extension of benefits or conversion to an individual policy.

On August 9, 1990, the Ramseys filed a lawsuit against Colonial Life in the Circuit Court of Hinds County, Mississippi, alleging that Colonial Life had refused payment of claims without an arguable reason, had committed the tort of reckless disregard of Plaintiffs' rights to benefits under the group policy, and had committed gross negligence with the intent to deceive by inducing Plaintiffs to convert to a policy with substantially lower limits than those available under the original group policy. By way of relief, Plaintiffs asked for a declaratory judgment that the group policy was still in force and effect as to claims related to Mr. Ramsey's quadriplegia up to the maximum limit of $2,000,000. In the alternative, Plaintiffs sought a judgment that Colonial Life was required to provide a conversion policy with the same limits and rates as existed under the group plan. Finally, Plaintiffs asserted a right to compensatory and punitive damages, together with pre-judgment interest, post-judgment interest, costs, and attorney's fees.

Colonial Life subsequently removed the state action to this Court. At some point subsequent to removal, Colonial Life tendered payment for all medical expenses incurred by Mr. Ramsey during the twelve month period following termination of Group Policy No. 330197.

II. CONCLUSIONS OF LAW

Rule 56 of the Federal Rules of Civil Procedure states in relevant part that summary judgment shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to summary judgment as a matter of law. Fed. R. Civ. P. 56(c). The United States Supreme Court has held that this language "mandates the entry of summary judgment, after adequate time for discovery and upon motion, against a party who fails to make a sufficient showing to establish the existence of an essential element to that party's case, and on which that party will bear the burden of proof at trial." *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986); *see also Moore v. Mississippi Valley State University*, 871 F.2d 545, 549 (5th Cir. 1989); *Washington v. Armstrong World Industries, Inc.*, 839 F.2d 1121, 1122 (5th Cir. 1988).

The party moving for summary judgment bears the initial responsibility of informing the district court of the basis for its motion and identifying those portions of the record in the case which it believes demonstrate the absence of a genuine issue of material fact. *Celotex*, 477 U.S. at 323. However, the movant need not support the motion with materials that negate the opponent's claim.

Id. As to issues on which the non-moving party has the burden of proof at trial, the moving party need only point to portions of the record that demonstrate an absence of evidence to support the non-moving party's claim. *Id.* at 323-24. The nonmoving party must then go beyond the pleadings and designate "specific facts showing that there is a genuine issue for trial." *Id.* at 324.

Summary judgment can be granted only if everything in the record demonstrates that no genuine issue of material fact exists. The district court, therefore, must not "resolve factual disputes by weighing conflicting evidence, . . . since it is the province of the jury to assess the probative value of the evidence." *Kennett-Murray Corp. v. Bone,* 622 F.2d 887, 892 (5th Cir. 1980). Summary judgment is improper merely where the court believes it unlikely that the non-moving party will prevail at trial. *National Screen Service Corp. v. Poster Exchange, Inc.,* 305 F.2d 647, 651 (5th Cir. 1962).

A. Preemption of State Law Claims Under ERISA

Initially, the Court must determine which body of substantive law applies in this case. Although Plaintiffs have cast the Complaint in terms of state law contract and tort claims, Defendant urges the Court that federal law is controlling in this case because all claims relate to an employee benefit plan within the purview of the Employee Retirement and Income Security Act ("ERISA"), 29 U.S.C. § 1001, *et seq.*

ERISA defines an "employee welfare benefit plan" as

> . . . any plan, fund or program which was heretofore or is hereafter established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment. . . .

29 U.S.C. § 1002(1). In construing the statutory language, an employee welfare benefit plan has routinely been found to exist

> if from the surrounding circumstances a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedure for receiving benefits. To be an employee welfare benefit plan, the intended benefits must be health, accident, death, disability, unemployment or [certain other specified] benefits[;] . . . the intended beneficiaries must include union members, employees, former employees or their beneficiaries; and an employer or employee organization, or both, and not individual employees or entrepreneurial businesses, must establish and maintain the plan, fund, or program.

Donovan v. Dillingham, 688 F.2d 1367, 1373 (11th Cir. 1982). The Donovan analysis has been approved by the United States Court of Appeals for the Fifth Circuit, *see Memorial Hospital System v. Northbrook Life Insurance Company*, 904 F.2d 236, 240 (5th Cir. 1990), and has been applied by this Court. *See Foxworth v. Durham Life Insurance Company*, 745 F. Supp. 1227, 1229 (S.D. Miss. 1990).

The Colonial Life policy at issue in this proceeding clearly qualifies as an ERISA plan pursuant to Donovan. The intended benefits are contained in the policy which was provided to Moulden Supply employees, the class of beneficiaries under the policy are Moulden Supply employees and their dependents, Moulden Supply and its employees each paid a percentage of the premium to finance the policy, and Moulden Supply had established a procedure for receiving benefits through a designated insurance clerk.

Because Plaintiffs' Complaint asserts only claims related to an employee welfare benefit plan that qualifies as an ERISA plan, ERISA is the exclusive source of substantive law to be applied in this matter, and all of Plaintiff's state law claims are effectively preempted by federal law. *See* 29 U.S.C. § 1144; *see also Metropolitan Life Insurance Company v. Taylor,* 481 U.S. 58 (1987); *Pilot Life Insurance Company v. Dedeaux,* 481 U.S. 41 (1987); *Davis v. Time Insurance Company,* 698 F. Supp. 1317 (S.D. Miss. 1988). Accordingly, all of the state law claims asserted in Plaintiffs' Complaint must be dismissed and the state law claims which Plaintiffs attempt to assert are "recharacterized" as claims for benefits under the provisions of ERISA.

> As the Supreme Court recently declared in *Metropolitan Life Ins. Co. v. Taylor,* 481 U.S. 58, 107 S. Ct. 1542, 95 L. Ed. 2d 55 (1987), common-law contract and tort claims based upon laws of general application, that is, not specifically related to insurance or employee severance or discrimination, are preempted by ERISA . . . to the extent that they relate to an employee benefit plan. Moreover, when beneficiaries bring

> such claims to recover benefits from a covered plan, those claims fall under ERISA's 29 U.S.C. § 1132(a)(1)(B), which provides an exclusive federal cause of action for the resolution of such claims. . . . Thus, . . . in addition to preempting the state-law claims, ERISA's preemptive and civil enforcement provisions operate to "recharacterize" such claims into actions arising under federal law.

Degan v. Ford Motor Company, 869 F.2d 889, 893 (5th Cir. 1989). With regard to several of the state law claims asserted by Plaintiffs, however, the Court notes that preemption under ERISA requires complete dismissal of the claims. Plaintiffs do not dispute that all benefits under the policy personal to Dianne Ramsey have been paid in full. Accordingly, she is no longer able to maintain a cause of action for benefits under ERISA, *see* 29 U.S.C. § 1132(a)(1)(B), and all claims asserted by Plaintiff Dianne Ramsey are hereby dismissed. Further, the Court notes that Plaintiffs have asserted a bad faith failure to pay claim and have asked the remedy of punitive damages. While such a claim and the remedy of punitive damages are available under Mississippi law, such a claim cannot be maintained under ERISA and must accordingly be dismissed. *See Pilot Life Insurance Company,* 481 U.S. at 55-57. In light of these rulings, the only issues left for decision are Plaintiff William A. Ramsey's right to benefits under the policy, his right to a conversion policy, and his right to recover attorney's fees.

B. Coverage Issues

The primary issues of law presented by the instant motions concern the scope of coverage afforded under Group Policy No. 330197. In construing the policy provisions relevant to the issue of coverage, the Court is mindful that the interpretation of policies falling under ERISA is governed by federal common law rather than state law. The United States Supreme Court has not only declared that ERISA preempts all state law claims, but has also declared that it was the intent of Congress in passing ERISA to have federal courts develop federal common law to regulate and enforce ERISA. *See Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 110 (1989). The United States Court of Appeals for the Fifth Circuit has recognized that the development of a body of federal common law is necessary under ERISA to promote the statutory concern "for uniformity in the law governing employee benefit plans," *In re Heci Exploration Company, Inc.,* 862 F.2d 513, 521 (5th Cir. 1988) and "to prevent the development of a competing line of cases decided under state law." *Heci,* 862 F.2d at 521.

Federal courts have developed certain guidelines for "creating" federal common law in interpreting ERISA plans.

> We start by restating the method of the statute: the benefit provisions of an ERISA-regulated group life insurance policy must be interpreted under principles of federal substantive law. [citations omitted]. We think it clear that the "federal common law of rights and obligations," [citation omitted], while still in formation, must embody common sense cannons of contract

> interpretation. Notwithstanding the ennobling purposes which prompted passage of ERISA, courts have no right to torture language in an attempt to force particular results or to convey delitescent nuances the contracting parties neither intended not imagined. To the exact contrary, straightforward language in an ERISA-regulated insurance policy should be given its natural meaning.

Burnham v. Guardian Life Insurance Company of America, 873 F.2d 486, 489 (1st Cir. 1989).

Other federal courts have derived rules of interpretation directly from the statutory requirements themselves. Noting that 29 U.S.C. § 1022(a)(1) requires written plan descriptions which are "calculated to be understood by the average participant," the court in *Brewer v. Lincoln National Life Insurance Company*, 921 F.2d 150, 154 (8th Cir. 1990), determined that the requirement of a written plan "provides a source from which we may fashion a federal common law rule: the terms [of a plan/policy] should be accorded their ordinary, and not specialized, meanings." *Brewer*, 921 F.2d at 154; *see also Evans v. Safeco Life Insurance Company*, 916 F.2d 1437, 1440 (9th Cir. 1990).

(1) Accident v. Expenses Policies

William Ramsey contends that, because the accident rendering him a quadriplegic occurred while Group Policy No. 330197 was in effect, the plan provides coverage up to the $2,000,000 policy limitation for all medical expenses related to the quadriplegia regardless of whether the plan was still in effect at the time the medical services were actually rendered. Alternatively stated,

Ramsey contends that medical expenses related to his quadriplegia are covered by the policy up to the $2,000,000 limitation because such expenses were "incurred" at the moment he was injured and the policy was in effect at that time. Conversely, Defendant argues that, irrespective of when the accident occurred, Group Policy No. 330197 provided coverage for medical expenses related to Mr. Ramsey's quadriplegia only if the policy was still in effect at the time that medical services were provided to Ramsey because medical expenses cannot be "incurred" until the services are actually rendered.

Defendant asserts that the following provisions of Group Plan No. 330197 are relevant to the issue of coverage for medical expenses arising after the termination of the policy:

> SECTION S
> MEDICAL BENEFITS
>
> To receive a benefit, you must have *covered medical expenses* that exceed the deductible.
>
> . . .
>
> COVERED MEDICAL EXPENSES
>
> These are the *usual and customary charges* for services and supplies which are
>
> a. ordered by a physician;
>
> b. necessary for the treatment of an illness or injury; *and*
>
> c. *incurred while insured.*
>
> . . .

SECTION W – GENERAL MEDICAL/DENTAL PROVISIONS DEFINITIONS AND CONVERSION PRIVILEGES

USUAL AND CUSTOMARY CHARGES

Usual charges are those normally charged by the provider for the specific medical care or service *rendered.*

Customary charges are those most often made by providers for similar services in the same geographic area.

(emphasis added). Applying these provisions to the facts of this case, the Court finds that Group Policy No. 330197 did not provide William Ramsey with coverage for medical expenses related to his quadriplegia beyond the date that the policy was terminated other than for that period of time beyond termination of the policy where an extension of benefits or a conversion policy may have offered medical coverage to Mr. Ramsey. The medical benefits section of the Colonial Life policy provides that, "to receive a benefit, you must have *covered medical expenses*. . . . " (emphasis added). Covered medical expenses are defined as "the *usual and customary charges* for services and supplies. . . . " (emphasis added). Usual and customary charges are defined as "those normally charged by the provider for the specific medical care or service *rendered.*" (emphasis added). Accordingly, the policy, by its very terms, provides that a specific medical care or service must be "rendered" before a benefit may be received under the policy. The Court therefore finds that no genuine issue of material fact exists as to Ramsey's claim for benefits under these provisions of the

policy and that Defendant is entitled to judgment on this issue as a matter of law.

(2) Extension of Benefits

Ramsey next contends that he is entitled to continuing medical coverage under the extension of medical benefits clause of Group Policy No. 330197. In this regard, the Court notes that the policy provides as follows:

> SECTION C – EFFECTIVE DATE AND TERMINATION OF INSURANCE
>
> TERMINATION OF INSURANCE
>
> Your insurance will end when:
>
> . . .
>
> c. premium payments stop;
>
> d. the group policy terminates.
>
> Dependents insurance will end when:
>
> . . .
>
> c. your insurance ends, unless by death.
>
> . . .
>
> EXTENSION OF MEDICAL BENEFITS
>
> If you or a dependent are totally disabled when premium payment stops, medical benefits will be continued, until the earlier of:
>
> a. 12 months from the day you became disabled;
>
> b. the date total and continuous disability ends;

c. you or the dependent are insured for similar medical benefits under another group plan. . . .

In applying the extension of benefits clause to the facts of this case, the Court notes that the parties agree that Ramsey was totally disabled at the time that premium payments stopped under the group policy. The parties further agree that Ramsey remains totally and continuously disabled to date, the condition set forth in subsection b. to the extension of benefits clause, and that Ramsey has not secured medical benefits under another group insurance plan, the condition set forth in subsection c. to the clause. The parties do dispute, however, the effect that subsection a. of the extension of benefits clause has on extended medical coverage for Ramsey.

Defendant contends that, in applying the extension of benefits clause to a particular case, each of the three subsections should be analyzed under the facts of the case and a date assigned to each of the subsections based upon those particular facts. The earliest of these three dates would then be the date at which any extension of benefits would terminate. Applying this analysis to the instant case, Defendant urges that, because subsections b. and c. of the extension clause continue to be applicable to date, and because subsection a. would produce a date of January 31, 1988, that being twelve months from the January 31, 1987, date on which Ramsey became disabled, any extension of benefits due to Ramsey terminated on January 31, 1988. Defendant maintains that this construction of the clause is proper although the policy itself did not actually terminate until July 31, 1989, eighteen months past the date on which Defendant insists that Plaintiff's right to an extension of benefits expired.

Not surprisingly, Plaintiff maintains that Defendant's construction of the extension of benefits clause is improper and that the clause must be applied in a manner that gives a consistent meaning to the whole clause, rather than focusing merely on the subsections to the clause themselves. In this regard, Plaintiff notes that the clause expressly states in mandatory language that medical benefits "will be continued" if an insured is totally disabled at the time that the policy is terminated. Plaintiff contends that, once the mandatory nature of the extension of benefits clause is recognized from its own express language, subsections a., b., and c. can be applied only in a manner that is consistent with that language. Accordingly, Plaintiff argues that, while it would be proper to apply the extension of benefits clause in such a way that benefits would terminate once the event described in subsection a., b., or c. occurred following the date that the extension of benefits clause went into effect, it would be improper to apply the subsection in a manner that would allow the mandatory extension of benefits to be cut off prior to the time at which the policy itself is terminated, which is the time the extension clause logically should go into effect. Applying this analysis to the instant case, Plaintiff urges that, because subsection a. of the extension clause would produce a termination date for the extension of benefits clause before the policy itself was terminated, subsection a. is not applicable and only subsections b. and c. can be used to terminate Plaintiff's right to an extension of benefits.

The Court, having considered the arguments advanced by both parties and being mindful of its duty to give "straightforward language in an ERISA-regulated

insurance policy . . . its natural meaning," *Burnham*, 873 F.2d at 489, concludes that Plaintiff is entitled to continued coverage under Group Policy No. 330197 through the extension of benefits clause. The extensions of benefits clause mandates that medical benefits "*will* be continued" (emphasis added) if an insured is totally disabled at the time that the policy is terminated. Accordingly, subsection a., b., and c. cannot be applied in a manner that conflicts with the mandatory extension of benefits envisioned by the clause as a whole. The Court therefore finds that, because the application of subsection a. in the manner contemplated by Defendant would terminate Plaintiff's right to an extension of benefits before the policy itself had terminated and because such a result would conflict with the mandatory extension of benefits required by the clause as a whole, subsection a. is nonapplicable in the instant matter, and Plaintiff is entitled to an extension of benefits until the requirements of subsections b. or c. are met, or the policy limit of $2,000,000 is exhausted, whichever occurs first. Because neither subsection b. nor c. can presently be applied to terminate Plaintiff's medical benefits under the extension clause and because the policy limit of $2,000,000 has not been exhausted, the Court finds that no genuine issue of material fact exists as to Plaintiff's entitlement to continued medical coverage under the policy and that Plaintiff is entitled, as a matter of law, to a judgment declaring his rights to continued medical coverage under Group Policy No. 330197 for the condition of quadriplegia until such time as the requirements of either subsection b. or c. of the extensions of benefits clause are met, or the policy limit of $2,000,000 is exhausted, whichever occurs first.

In light of this ruling, the Court further finds that, because coverage for Ramsey was available under the extension of benefits clause from the date of termination of the group policy, it was not necessary for Ramsey to pay premiums on a conversion policy in order to secure insurance coverage from Defendant for the period immediately following termination of the group policy. Accordingly, the Court finds that no genuine issue of material fact exists with regard to Plaintiff's entitlement to have the $1,400 which he had paid in premiums on the conversion policy returned and a judgment should be entered in favor of Plaintiff for that amount as a matter of law.[1]

C. Conversion Rights

Plaintiff has asked this Court, in the event that the Court finds Plaintiff is not entitled to coverage under Group Policy No. 330197, to consider Plaintiff's rights to

---

[1] With regard to the relief available to Ramsey on the extension of benefits clause claim, the Court notes that the Complaint filed in this matter does not request payment of any prior medical expenses incurred by Ramsey. Further, the evidence placed before the Court in support of Plaintiff's Motion for Summary Judgment does not contain any unpaid medical bills which Ramsey may have incurred to date. As the Court has previously noted, *supra*, p.5, Defendant has tendered payment for all medical expenses incurred by Ramsey during the twelve month period following termination of Group Policy No. 330197. Accordingly, the judgment entered in this cause will not include an award for medical expenses previously incurred, as no such relief was requested, nor is it supported by the evidence in this case.

a conversion policy providing the same coverage and premium payments as that afforded Plaintiff under the group plan. Although the Court has found Plaintiff to be entitled to coverage under group plan and therefore has no need to address an argument in the alternative, it will address the issue since it is clear Defendant has complied with its duty under federal law, *see* 28 U.S.C. §§ 1161-1168, to offer conversion rights to its insured. In the case of *Baker v. Washington National Life Insurance Co.*, 823 F.2d 156, 159 (5th Cir. 1987), the United States Court of Appeals for the Fifth Circuit held that where "a company includes an undertaking to offer a conversion policy [in its contract of insurance] and its promise is no more definite than it will issue an undisclosed, undefined form of conversion policy, it is bound to furnish at least one that is not less advantageous to the insured than the coverage it agrees to convert." Although the court declined to adopt a standard method for insurance companies to utilize in apprising insureds of their conversion rights, the court did note that companies could avoid the harsh result of *Baker* by ensuring that conversion coverages were available for inspection by the prospective insured. *Baker*, 823 F.2d at 159. In the instant matter, Defendant has produced evidence which establishes that it complied with *Baker* by having a copy of the conversion policy application which showed available coverages and premiums on file with the employer, Moulden Supply. Accordingly, the Court finds that no genuine issue of material fact exists with regard to Plaintiff's conversion claim and that Defendant is entitled to judgment on the claim as a matter of law.

D. Attorney's Fees

Finally, Plaintiff has requested an award of attorney's fees should he prevail on the merits of this case. In *Pitts v. American Security Life Insurance Company*, 931 F.2d 351, 358 (5th Cir. 1991), the factors to be considered when awarding attorneys' fees in ERISA cases were set out as follows:

> (1) the degree of the opposing party's culpability or bad faith;
>
> (2) the ability of the opposing party to satisfy an award of attorney's fees;
>
> (3) whether an award of attorney's fees would deter other persons who will be acting under similar circumstances;
>
> (4) whether the party seeking attorney's fees sought to benefit all participants in an ERISA plan or to resolve a significant legal question under ERISA; and
>
> (5) the relative merits of the parties' positions.

In regard to these factors, the Court finds that the Defendant has contested coverage on genuine legal issues and is not guilty of bad faith. The Court further finds that Defendant could pay attorneys fees if required, but an award of attorney's fees would not act as a deterrent to others because these same circumstances are unlikely to re-occur. Additionally, Plaintiffs suit did not attempt to benefit other ERISA participants, nor did it resolve any significant legal issue under ERISA. This case involved an unusual factual situation relative to the language of the policy in question, and Defendant's position on the merits was relatively strong. Accordingly, the Court concludes that the instant matter is not an appropriate ERISA

case in which to make an award of attorney's fees. Accordingly, the Court finds that no genuine issue of material fact exists as to Plaintiff's claim for attorney's fees and that judgment should be entered for Defendant on such claim as a mater [sic] of law.

IT IS THEREFORE ORDERED that Plaintiffs' Motion for Summary Judgment be granted as to the claim asserted by Plaintiff William A. Ramsey, Jr., under the extension of benefits clause of Group Policy No. 330197.

IT IS FURTHER ORDERED that Defendant's Cross-Motion for Summary Judgment be granted as to all other claims asserted in this lawsuit.

IT IS FURTHER ORDERED that a Final Judgment consistent with this Memorandum Opinion and Order be entered in this cause.

SO ORDERED this the 8th day of June, 1992.

/s/ William H. Barbour, Jr.
CHIEF JUDGE

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
JACKSON DIVISION

WILLIAM A. RAMSEY, JR. **PLAINTIFF**

VERSUS **CIVIL ACTION NO. J90-0452(B)**

THE COLONIAL LIFE INSURANCE COMPANY OF AMERICA d/b/a CHUBB LIFEAMERICA **DEFENDANT**

PLAINTIFF'S NOTICE OF APPEAL PURSUANT TO RULE 3(a) OF THE FEDERAL RULES OF APPELLATE PROCEDURE

(Filed Jun. 05, 1995)

COMES NOW William A. Ramsey, Jr. and files this his Notice of Appeal from the Order entered in this cause on May 9, 1995, denying Plaintiff's Motion to Quantify Declaratory Judgment entered in this cause by the Court, and being aggrieved by said Order, appeals to the Circuit Court of Appeals for the Fifth Federal Circuit.

Respectfully submitted,

/s/ James W. Nobles, Jr.
JAMES W. NOBLES, JR.

One of the Attorneys for Plaintiff,
William A. Ramsey, Jr.

CERTIFICATE OF SERVICE

I, James W. Nobles, Jr., one of the Attorneys of Record for the Plaintiff, do hereby certify that I have this day mailed by United States mail, postage fully prepaid,

a true and correct copy of the above and foregoing document to:

Robert C. Boyd, Esquire
Boyd & Aiken
840 East River Place, Suite 610
Post Office Box 24207
Jackson, Mississippi 39225

THIS, the 2nd day of June, 1995.

/s/ James W. Nobles, Jr.
JAMES W. NOBLES, JR.

JAMES W. NOBLES, JR.
MSB #3873
125 South Congress Street
Suite L-182, Capital Towers Bldg.
Post Office Box 1733
Jackson, Mississippi 39215-1733
Telephone: (601) 948-1757
Facsimile: (601) 354-0903
Texas State Bar #15053040

and

Pat M. Barrett, Jr.
MSB #2067
Barrett Law Firm
404 Court Street North
Post Office Drawer 631
Lexington, Mississippi 39095
Telephone: (601) 834-2376
Facsimile: (601) 834-2409
Attorneys for Plaintiff
William A. Ramsey, Jr.
G:\RAMSEY\APPEAL

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
JACKSON DIVISION

WILLIAM A. RAMSEY, JR. PLAINTIFF

VS. CIVIL ACTION, NO. J90-0452(B)

THE COLONIAL LIFE INSURANCE COMPANY OF AMERICA, d/b/a CHUBB LIFEAMERICA DEFENDANT

MOTION TO QUANTIFY PRIOR JUDGMENT AND FOR DECLARATORY RELIEF

(Filed Sep. 21, 1994)

Comes now plaintiff, William A. Ramsey, Jr., pursuant to F.R.C.P. 57, 28 U.S.C. §§ 2201, 2202 and 28 U.S.C. §1651, and moves the Court to quantify and declare the precise amount that defendant is indebted to plaintiff as of the date of the order hereafter rendered on this Motion pursuant to this Court's Final Judgment rendered in this cause on June 8, 1992, based on this Court's Memorandum Opinion and Order reported at 843 F. Supp. 1103, as affirmed by the United States Court of Appeals for the Fifth Circuit on January 27, 1994, reported at 12 F.3d 472.

Movant alleges that such indebtedness from August 1, 1990, to August 1, 1994, is in the amount of $300,703.00, as itemized on Exhibit A attached hereto and incorporated herein by reference.

As shown by correspondence between the parties through their attorneys, attached hereto as Exhibits B through H and incorporated herein by reference, defendant essentially refuses to pay to plaintiff the coverage to which this Court and the Fifth Circuit declared plaintiff

was entitled under policy number 330197, "as though it had never been canceled by Mouldin Supply Company, Inc.," thereby entitling plaintiff to an award of reasonable attorneys' fees necessitated by such continued wrongful refusal to pay on the part of defendant.

In the absence of the relief requested herein, defendant will be unjustly enriched by its original wrongful termination of insurance coverage.

Movant requests a speedy hearing of this action and that the Court advance it on the calendar, as provided by F.R.C.P. 57.

Movant further prays for general relief.

Respectfully submitted,

WILLIAM A. RAMSEY, JR.,
PLAINTIFF/MOVANT

BY: /s/ Pat M. Barrett, Jr.
Pat M. Barrett, Jr.
(MBN 2067) and
James W. Nobles, Jr.
(MBN 24620)
Attorneys for Plaintiff

OF COUNSEL:

BARRETT LAW OFFICES
P. O. Drawer 631
404 Court Square North
Lexington, Mississippi 39095
Telephone No.: (601) 834-2376

JAMES W. NOBLES, JR., ESQ.
P. O. Box 1733
Jackson, Mississippi 39215-1733
Telephone No.: (601) 948-1757

CERTIFICATE OF SERVICE

I, Pat M. Barrett, Jr., hereby certify that I have this day delivered a true and correct copy of the foregoing Motion to Quantify Prior Judgment and for Declaratory Relief to Honorable Robert C. Boyd, at his usual and last-known address of Boyd & Akin, P. O. Box 24207, Jackson, Mississippi 39225, by postage-paid, United States mail.

This the 20 day of September, 1994.

/s/ Pat M. Barrett, Jr.
Pat M. Barrett, Jr.

EXHIBIT A

What Chubb LifeAmerica would have paid from August 1, 1990, to August 1, 1994, under policy number 330197 if it had never been cancelled:

1.	*Attendant care* (4 yrs. – 16 hrs./day – $10.25/hr.)	239,440.00
2.	*Wheelchair*	17,000.00
3.	*Van*	15,000.00
4.	*Dr. Gary Nelson*	85.00
5.	*Prescription drugs*	450.00
		$ 271,975.00
	Plus Interest*	28,728.00
		$ 300,703.00

* Interest calculation on next page

Interest Calculation

1st year	08-01-90 to 08-01-91
2nd year	08-01-91 to 08-01-92
3rd year	08-01-92 to 08-01-93
4th year	08-01-93 to 08-01-94

[16 hrs./day x 365 x $10.25/hr. = $59,860/yr. x 8% = $4,788.00]

Interest on:	Interest period:	Totals:
59,860.00	08-01-91 to 08-01-92$ (on 1st yr. debt)	4,788.00
119,720.00	08-01-92 to 08-01-93 (on 1st & 2nd yr. debt)	9,576.00
179,580.00	08-01-93 to 08-01-94 (on 1st, 2nd & 3rd yr. debt)	14,364.00
		$28,728.00

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
JACKSON DIVISION

WILLIAM A. RAMSEY, JR. PLAINTIFF

VS. CIVIL ACTION, NO. J90-0452(BN)

THE COLONIAL LIFE INSURANCE COMPANY OF AMERICA, d/b/a CHUBB LIFEAMERICA DEFENDANT

DEFENDANT'S RESPONSE TO PLAINTIFF'S MOTION TO QUANTIFY PRIOR JUDGMENT AND FOR DECLARATORY RELIEF

(Filed Oct. 12, 1994)

Defendant Colonial Life Insurance Company of America ("Colonial Life") responds to the Plaintiff's most recent filing, dated September 20, 1994, (denominated as a "motion") as follows:

1. This Court lacks jurisdiction to entertain the recent "motion" filed on behalf of the Plaintiff. This Court entered final judgment on June 9, 1992. Copy attached as Exhibit "1". The Fifth Circuit Court of Appeals affirmed the judgment of the District Court on January 27, 1994. Copy of Fifth Circuit affirmance attached as Exhibit "2". As noted by Plaintiff's own counsel, the judgment "as affirmed by the Fifth Circuit has now become final and non appealable (sic)." See Exhibit "B" to Plaintiff's "motion" at ¶ 1. The Plaintiff's "motion" was not mailed until September 20, 1994. The Plaintiff's "motion" (a) is untimely considering the affirmance by the Fifth Circuit

in January 1994, and (b) is not authorized by any provision found in the Federal Rules of Civil Procedure. Therefore, Plaintiff's "motion" must be dismissed.

2. The "relief" requested in Plaintiff's "motion", whereby the District Court is requested to quantify the amount of its prior judgment, is without authority. The judgment of the District Court dated June 9, 1992, does not award any of the "relief" sought in Plaintiff's September 20, 1994 "motion". On page 13 of the District Court's opinion this Court ruled that "a specific medical care or service must be 'rendered' before a benefit may be received under the policy." The majority of the items/services requested as relief in Plaintiff's "motion" have not been "rendered", and, therefore, are not recoverable. For instance, item number 1 on Plaintiff's Exhibit "A" (attendant care) has not been "rendered" to the Plaintiff. Some minor items/services actually "rendered" to Plaintiff (*or to be rendered*) have been submitted for review by way of the claims procedure, and are being processed. The "relief" requested in Plaintiff's September 20, 1994 "motion" is not authorized by the District Court's judgment nor was it requested by way of affirmative relief in the original Complaint. Therefore, Plaintiff's September 20, 1994 "motion" must be dismissed.

3. Plaintiff's September 20, 1994 "motion" is seeking relief which was not requested in the original Complaint nor awarded in the judgment. Plaintiff is trying to avoid the finality of the final judgment by seeking an untimely "reconsideration" of the District Court's original opinion more that two (2) years following it's [sic] original issuance and more that nine (9) months after the ruling of the Fifth Circuit. There are no provisions in the Federal Rules

of Civil Procedure authorizing the "motion" filed on behalf of the Plaintiff. Therefore, Plaintiff's "motion" must be dismissed.

4. Finally, as Plaintiff did not file a brief setting forth any legal arguments supporting the "motion", Colonial Life reserves further comment until such time as further response may be necessary or appropriate.

Respectfully submitted,

THE COLONIAL LIFE
INSURANCE COMPANY
OF AMERICA

BY: BOYD & AKIN

BY: /s/ Robert C. Boyd
ROBERT C. BOYD
Miss. Bar No. 4218

COUNSEL FOR DEFENDANT:

ROBERT C. BOYD
BOYD & AKIN
POST OFFICE BOX 24207
JACKSON, MS 39225-4207

TELEPHONE: (601) 352-6221
FACSIMILE: (601) 352-6303

CERTIFICATE OF SERVICE

I, Robert C. Boyd, attorney for Defendant The Colonial Life Insurance Company of America, certify that I have this day forwarded by United States Mail, postage prepaid, a true and correct copy of the above and foregoing DEFENDANT'S RESPONSE TO PLAINTIFF'S

MOTION TO QUANTIFY PRIOR JUDGMENT AND FOR DECLARATORY RELIEF to the following:

Mr. James W. Nobles, Jr.
Attorney-at-Law
Post Office Box 1733
Jackson, MS 39215-1733

Mr. Pat M. Barrett, Jr.
Barrett Law Office
Post Office Drawer 631
Lexington, MS 39095

ATTORNEYS FOR PLAINTIFF

THIS the 11TH day of October, 1994.

/s/ Robert C. Boyd
ROBERT C. BOYD

IN THE UNITED STATES DISTRICT COURT FOR THE
SOUTHERN DISTRICT OF MISSISSIPPI
JACKSON DIVISION

WILLIAM ALLAN RAMSEY, JR.
AND DIANNE W. RAMSEY PLAINTIFFS

VERSUS CIVIL ACTION NO. 90-0463(B)

COLONIAL LIFE INSURANCE COMPANY,
d/b/a CHUBB LIFEAMERICA DEFENDANT

AFFIDAVIT OF WILLIAM ALLAN RAMSEY, JR.

(Filed Mar. 7, 1995)

STATE OF MISSISSIPPI

COUNTY OF HINDS

PERSONALLY APPEARED BEFORE ME, the undersigned authority in and for the County and State aforesaid, William Allan Ramsey, Jr. who after being by me first duly sworn states on oath the following:

1. That on January 31, 1987, I sustained an injury which rendered me a full quadriplegic due to fracture of the C4 vertebra in my neck and damage to the spinal chord from C2 to C7. I am and have been continuously and totally disabled since that date and will be so totally disabled for the remainder of my life.

2. Due to my quadriplegia, I am able to move only my head and the upper parts of my shoulders. I am totally paralyzed from my neck down, except for that slight shoulder movement, and am unable to use my hands, arms, legs, feet or any other member of my body and I am and have been totally dependent on others for

sustenance and the necessities of life, including all personal hygiene and care. I spend most of my waking hours in a motorized wheelchair, which I am able to control by means of a sip and puff system. The rest of the time I am confined to my bed. I require the attendance of others on a 24 hour basis each and every day.

3. From August 28, 1987, the day I was discharged from Mississippi Methodist Rehabilitation Center, the Colonial Life Insurance Company, d/b/a Chubb Life-America, under the Moulden Supply Company Group Policy, Policy No. 330197, under which I was covered as spouse of Dianne W. Ramsey, provided 16 hours per day attendant care through First Quality Care and then Kimberly Quality Care, a local home health care company, through July 30, 1990. These services were required by my condition, which remains virtually unchanged to this date. In July of 1990, the Colonial Life Insurance Company, d/b/a Chubb LifeAmerica, advised Kimberly Quality Care that they would pay for no services rendered after July 30, 1990, apparently confirming what they had told me by phone that my total disability extension of coverage would terminate 12 months after Policy No. 330197 was terminated. To the best of my knowledge, I never received written notice of termination.

4. Beginning August 1, 1990, the State of Mississippi, through the Independent Living Division of the Department of Vocational Rehabilitation, has paid for up to 150 hours a month of attendant care from $4.00 to $4.25 per hour from that date to this. Accordingly, I have agreed to reimburse the State of Mississippi for such amount spent on me that would ordinarily have been paid for by my health insurance carrier at such time my

health insurance carrier compensates me for the care it has wrongfully withheld since July 31, 1990. Additionally, Independent Living has assisted me with other needs such as ramps, wheelchair repairs, and replacement of a warn [sic] out wheelchair. To date, the State of Mississippi's expenditures on my behalf total approximately $37,000.00.

5. Other than the amounts of monies available to me from the State of Mississippi for attendant care and other needs, I was without funds with which to engage the services of attendant care personnel. Since my release from Mississippi Methodist Rehabilitation Center, my daily needs have remained virtually unchanged. Each day in order to defecate, someone must place a suppository in my rectum and clean up the resulting mess. I am unable to bathe myself; I am unable to get from the bed to my wheelchair; and I am unable to feed myself or even drink a glass of water without assistance. Being without funds and without the coverage which was provided to pay the bills for attendant care and other needs and due to the fact that the Colonial Life Insurance Company has denied my claims and told me that it would do no good to submit further claims after July 30, 1990, because it considered the coverage to be at an end and it would not honor those claims, my family was forced into providing virtually all of my attendant care, except that provided by the State of Mississippi. That attendant care was incurred on a daily basis and administered to me by my wife and our three children. My wife has had to maintain one full-time job and one or two part-time jobs just to keep our family together and keep from losing our home. From July 31, 1990, until after the Fifth Circuit Court Decision, I

did not file any claim forms with Colonial Life because litigation was pending and because Colonial Life had told me that no other or further claims would be considered or paid. Consequently, my wife and our daughter and two sons were required to provide the attendant care which was denied me due to the refusal of Colonial Life to pay claims while it contended that there was no further coverage available to me.

6. Since receiving the ruling from the Fifth Circuit Court of Appeals, Colonial Life has had me examined by Mrs. Jackie Moore, their Nurse Case Manager, and by Dr. Rahul Vohra, a pain specialist/internal medicine specialist, who, in reply to my explanation of my situation with Colonial Life, referred to Colonial Life's position as a "no-brainer" in its contention that I need less than 16 hours per day attendant care. Both Mrs. Moore and Dr. Vohra gave me the impression that they fully agreed that I need and will continue to need full-time attendant care on a daily basis. As late as September 23, 1994, Colonial Life refused to pay claims submitted, still contending that coverage ceased and no coverage is available to pay the claims submitted. Several weeks after demanding that I be examined by their Nurse Case Manager and by a doctor of their choice, they finally tendered to me an offer to pay for attendant care for only 8 hours per day, an offer which is not acceptable because I am awake and in need of care from 6:00 a.m. or earlier until 10:00 p.m. or later every day. Before my injury, I stood nearly 6 feet tall and weighed approximately 175 pounds. My weight today is approximately 200 pounds and I am unable to move myself or to assist others in moving me. Colonial Life provided me with 16 hours per day attendant care

from August 28, 1987, through July 30, 1990, not because I only needed 16 hours per day attendant care, but because we agreed to only 16 hours per day attendant care in order to conserve coverage.

7. Since July 31, 1990, my attendant care needs have been provided through the auspices of the State of Mississippi and by my family. Consequently, I have been forced to spend many hours alone, virtually a prisoner in my own home. On a number of occasions, I have had to call the Clinton, Mississippi Police Department to come to my aid and, on other occasions, when I could not reach a phone due to the failure of my wheelchair, I have been forced to sit out of position and in misery until help arrived. This situation has caused me immeasurable worry, anguish, and consternation because I have had to depend on my wife and our children to take time from their lives to provide me attendant care that should have been and should be provided by Colonial Life Insurance Company. If the coverage had been available during the period that Colonial Life Insurance Company refused to honor coverage, I would have continued to receive attendant care through a home health care company and would not have had to depend on my family for those services. The value of services which were provided before Colonial Life denied coverage was approximately $10.25 per hour for regular time for two 8-hour shifts. Sixteen hours per day at $10.25 per hour for 365 days per year amounts to $59,860.00 per year. Those services were incurred and furnished to me by my wife, our children, and attendants hired through the auspices of the State of Mississippi.

8. On occasion, when our finances would allow, my wife and I would pay for some temporary help. Like those hired through Independent Living, these persons would be, for the most part, unqualified persons that would have to be trained by me. We have been able to hire this temporary help only on rare occasions because my wife's three jobs and my Social Security have been insufficient to even maintain our standard of living, much less pay for attendant care.

Affiant further sayeth not.

WITNESS MY SIGNATURE, this the 6th day of March, A.D., 1995.

/s/ William Allan Ramsey, Jr.
WILLIAM ALLAN RAMSEY, JR.

SWORN TO AND SUBSCRIBED BEFORE ME, this the 6th day of March, A.D., 1995.

/s/ Conni Su Herrington
NOTARY PUBLIC

My Commission Expires:

MISSISSIPPI STATEWIDE NOTARY PUBLIC
MY COMMISSION EXPIRES FEB. 16, 1998

CERTIFICATE OF SERVICE

I, James W. Nobles, Jr., one of the attorneys for the Plaintiff, William A. Ramsey, do certify that 1 [sic] have served a true copy of the above and foregoing Affidavit of William A. Ramsey on Honorable Robert Boyd, Attorney for the Defendant, by mailing to him by United States Mail, postage paid, a true copy hereof.

This the 6th Day of March, A. D., 1995

/s/ James W. Nobles, Jr.
James W. Nobles, Jr.

JAMES W. NOBLES, JR.
MSB #3873
Texas State Bar #15053040
P.O. Box 1733
Jackson, MS 39215-1733
Telephone: (601) 948-1757
Facsimile: (601) 354-0903

and

Pat Barrett, Jr.
Barrett Law Firm
P. O. Box 631
Lexington, Mississippi, 39095
Telephone: 601-834-2376
Facsimile: 601-834-2904

ATTORNEYS FOR PLAINTIFF
WILLIAM A. RAMSEY

[LOGO] CHUBB[SM]
LifeAmerica

SECTION S
MEDICAL BENEFITS

To receive a benefit, you must have covered medical expenses that exceed the deductible. If you do, we will pay you all or part of the excess. The percent payable is shown in the schedule of insurance. So are the maximum amounts covered and maximum benefit. The schedule of insurance is in Section A.

Deductible

The deductible consists of two parts:

a. cash deductible. This is the first portion of covered expenses that are not payable under the policy. It applies each year, January 1st through December 31st;

b. benefits deductible. This is any other medical benefit sponsored by your employer. It applies even if you elect not to join. These other benefits may be provided by us, another insurer, or self-funded by your employer.

The cash and benefits deductibles are described in the schedule of insurance.

Only one cash deductible will apply to expenses from an accident injuring more than one family member in the year it occurs.

Covered Medical Expenses

These are the usual and customary charges for services and supplies which are:

a. ordered by a physican [sic];

b. necessary for the treatment of an illness or injury; and

c. incurred while insured.

They must be made by a licensed:

a. hospital;

b. free standing surgical center;

c. residential treatment facility;

d. home health care agency for:

1. part-time or intermittent nursing care;
2. part-time or intermittent home health aide services;
3. physical, occupational or speech therapy; and
4. medical social work, nutrition services and special meals.

e. physican [sic];

f. surgical specialist for a second surgical opinion;

g. psychologist;

h. anesthetist;

i. registered nurse;

j. nurse midwife;

k. practical nurse when hospitalized;

l. registered physical therapist;

m. speech therapist to correct a normal speech pattern that was changed by an accident or sickness that occurred while insured;

n. radiologist;

o. laboratory;

p. ambulance for local service to the nearest hospital; and

q. pharmacist or institution for drugs or medicines. They must be approved by the Federal Drug Administration and may only be dispensed with a prescription.

The definitions of many of the above terms are found in Section W.

Also included are charges for:

a. railroad or commercial airline service to the nearest hospital able to treat the condition. It must be a regularly scheduled trip;

b. artificial limbs or eyes;

c. casts, splints, trusses, braces or crutches;

d. oxygen and the rental of equipment for its administration; and

e. rental of a wheelchair, hospital type bed, or equipment for the treatment of respiratory paralysis. If the total covered rental charge exceeds the purchase price, we will not cover more than the purchase price.

Successive Periods of Hospitalization

Successive confinements will be considered one hospitalization unless they are:

a. due to entirely unrelated causes; or

b. separated by 90 days.

[LOGO] CHUBB℠ LifeAmerica

SECTION S – SOCIAL WORKER COVERAGE

Certified Social Worker

For mental, nervous or emotional disorders, covered expenses shall include the charges of a certified social worker. A certified social worker is one who:

a. is certified by the state; and

b. has three years' post degree experience in psychotherapy.

The three years' experience must be either:

a. in a facility that is licensed by the state or federal government. It must provide services for diagnosis or treatment of mental, nervous or emotional disorders or ailments; or

b. under the supervision of:

   1. a psychiatrist;

   2. a certified and registered psychologist; or

   3. another certified social worker.

The experience and requirement must meet any standards set by the state board for social work.

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SECTION F – ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PROVISIONS

Description of Benefit

This benefit is paid for losses resulting from and within 90 days of an accident.

Your full benefit is paid for loss of life. Death must result, directly and independently of all other causes from accidental bodily injury. The 90 day limit will not apply to death if, at the end of 90 days, you are comatose or are being kept clinically alive by an artificial life support system. The full benefit is also paid for loss of both feet, both hands or the irrecoverable sight of both eyes. A hand must be permanently severed at or above the wrist. A foot must be permanently severed at or above the ankle.

One half benefit is paid for loss of one hand, one foot or the sight of one eye.

You will not be paid more than the amount of your benefit for all losses resulting from any one accident. payment will be made to you, if living. If you have died, your beneficiary will be paid.

The amount of your benefit is shown in the schedule of insurance.

Limitations

The insurance does not cover losses resulting from or caused by:

a. intentional self-destruction;

b. intentional self-inflicted injury;

c. war or any act of war, declared or undeclared;

d. commission of a felony;

e. directly or indirectly from illness or disease of the body or mind or its medical or surgical treatment;

f. ptomaine or any infection unless it results from an injury caused by accident; or

g. the voluntary use of any "controlled substance," defined below, unless as prescribed by a physician.

Definition – "Controlled Substances" are those subject to the Federal Controlled Substances Act. They are further defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970.

Occupational Accidents and Sicknesses

No benefits are payable for an injury arising out of or in the course of employment. Sicknesses eligible for benefits under a worker's compensation act or similar law are not covered.

Pre-Existing Condition Limitation

If medical care was received during the six months prior to being insured, benefits will be limited. For the same or related causes, not more than the preexisting condition maximum benefit will be paid until the earlier of:

a. the end of a three month period, starting while insured, during which no medical care was received for the same cause; or

b. the end of a twelve month period during which the person was insured under the policy.

Medical care includes any treatment, services, consultation or medication.

The pre-existing condition maximum benefit is shown in the schedule of insurance.

Coordination of Benefits

This provision applies if you or your dependents are covered under any other group medical or dental plan.

This includes any group insurance policy, employer sponsored plan, union plan or employee organization program. It also includes any plan provided by law, including a mandatory motor vehicle no-fault law, if the law does not require us to pay first.

Most plans provided for coordination of benefits. Where other coverage exists, benefits under our plan may be reduced. One plan will pay regular benefits as they would if no other insurance existed; the other the balance. From all sources, you may receive up to 100% of covered expenses in a calendar year.

We will be prime insurer and pay our regular benefits:

a. when the employee is the patient; or

b. on children of a male employee.

If you are divorced or separated, we will pay first on children's claims if you:

a. have custody of he child; or

b. are legally responsible by court decree.

In all other cases, we will pay the balance after the other plan has paid its full benefit.

To administer this provision, we may contact and exchange information with the other plan or its insurer. We reserve the right to pay directly any amount due them.

We will abide by the National Association of Insurance Commissioners' Model Coordination of Benefits provision, if there should be a question on who pays first.

Pregnancy and Newborn Child Care

The mother's covered expenses that result from a pregnancy will be paid the same as an accident or sickness.

For a newborn child, expenses resulting from:

a. illness;

b. injury;

c. premature birth;

d. congenital defect; or

e. birth abnormality;

are included.

There are no benefits for other nursery charges or pediatric care.

Medicare Reduction

This applies to persons eligible to join Medicare. Medicare means Title 18 of the Social Security Act.

After determining our normal medical benefit, it will be reduced. The reduction will equal the amount that Medicare would pay a fully enrolled person. It will apply even if you do not fully enroll.

For maximum benefits, you must sign up for Medicare when first eligible.

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LifeAmerica

Plaintiff's Exhibit 1
CERTIFICATE OF INSURANCE

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1. Employee Last Name: Ramsey — First: A — Middle Initial: D

Effective Date 8-1-86

2. Name of Employer
Moulden Supply Co.

Group Policy Number
330197

3. Name of Life and Accidental Death and Dismemberment Beneficiary, and Relationship to the Employee

Last Name	First	Middle Initial	Relationship
Ramsey	William	A	Husband

4. Full-time Employment Date

Month	Day	Year
9	6	83

5. Date of Birth

Month	Day	Year
10	3	48

6. Do you wish to have MEDICAL COVERAGE for your spouse and/or dependent chidlren? X YES ___ NO

6a. S.S.#: 422-60-9432

This certificate describes the benefits which we, The Colonial Life, provide under a group policy.

*If you meet the eligibility requirements on the next page, you will be insured on the date shown above. If you are not at work at the employer's regular place of business on that date, your insurance will be effective when you return.

Benefits that result from your death will be paid to your beneficiary. All other payments will be made to you.

/s/ Frederick S. Condon	/s/ John F. Sandoz
Secretary	President

The Colonial Life Insurance Company of America
a member of the Chubb Group of Insurance Companies
Home Office: 8 Sylvan Way/Parsippany, N.J. 07054

[LOGO] CHUBB[SM] SECTION A – ELIGIBILITY AND
LifeAmerica SCHEDULE OF INSURANCE

Policy No. 330197 Issued To: Moulden Supply Co. Inc.

Employees Eligible

All full-time employees of Moulden Supply Co. Inc. are eligible to join after completion of one month of full-time employment with the employer.

Commissioned salespeople are eligible to join only if they:

a. work full-time (not less than 30 hours a week) for the employer/policyholder; and

b. derive 90% of their earnings from the sale of the employer/policyholder's products.

Part-time employees and employees whose regular work schedule is less than 30 hours a week are not eligible. You must be at work on a full-time basis at your employer's regular place of business for insurance to take effect. if you are not, insurance will take effect when you return to full-time work.

Dependents

Your spouse is eligible to be enrolled under the policy.

So are any of your unmarried children, if they are:

a. less than 21 years of age and not employed on a regular full-time basis;

b. 21 but less than 26 years of age and a full-time student; or

c. 21 or older and incapable of earning a living due to mental or physical handicap. The child must have become incapable prior to age 21 and while insured as a dependent.

This includes adopted, step and foster children.

If your child does not live with you, proof of dependence on you or legal responsibility for support is required.

A person insured as an employee cannot be covered as a dependent.

To become insured, dependents, other than a newborn child, must not be confined in a hospital or nursing facility. If they are, their insurance will take effect when they are discharged.

Schedule of Insurance

Your benefits are outlined in the following indexed schedule of insurance.

No increase will be made in any amount of insurance unless you are at work on a full-time basis at your employer's regular place of business on the day it takes effect.

Alcoholism and Drug Addiction

for detoxification of alcoholism and drug addiction, benefits are payable for covered inpatient or outpatient charges. This may be in a licensed hospital, residential treatment or detoxification facility. When not confined, the benefit payable is shown in the schedule of insurance.

Mental Disorders

For treatment of:

a. nervous disorders;

b. psychoses;

c. neuroses; or

d. psycho-physiological disorders;

benefits are payable for 60 days of covered charges in any 12 months when confined. This may be in a hospital or residential treatment facility. When not confined, the benefit payable is shown in the schedule of insurance.

Sex Therapy and Educational Counseling

Sex therapy and educational counseling charges are not covered.

Blood and Blood Plasma

Charges for administration and processing are covered. But the cost of the first three pints of whole blood or concentrated red blood cells in each confinement is not. Any excess over three pints is covered, unless replaced.

Service Type Care

There is no benefit for expenses that the patient is not legally required to pay. This does not include care paid by Medicaid.

Treatment Outside the Country

Benefits are payable for treatment received in;

a. The United States;

b. Canada;

c. Puerto Rico; and

d. The U.S. Virgin Islands.

No benefits are payable if the patient leaves these areas to be treated. But, if the patient leaves for non-medical reasons, benefits will be paid for an illness or accident that occurs during the first 120 days away. The 120 day limit will not apply if the patient is away on employer business.

War

Expenses that result from an act of war are not covered.

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SECTION W – GENERAL MEDICAL/DENTAL PROVISIONS EXCLUSIONS AND LIMITATIONS

Routine Examinations

Medical benefits are provided for treatment of accidents or sicknesses. Preventative or health maintenance care is not covered. Visits or tests that are not incident to a given diagnosis are not covered.

Non-standard Treatment

Treatment that is experimental in nature or not generally accepted medical or dental practice in the United States is not covered.

Services Rendered by Family Members

Services by your or your spouse's father, mother, son, daughter, brother or sister are not covered.

Employer Sponsored Facilities

No benefits are payable for treatment rendered:

a. in a clinic, dental or medical facility sponsored or maintained by the patient's employer; or

b. by an employee of the patient's employer.

Visual and Hearing Care

Routine eye exams and refractions, eye glasses, contact lenses, hearing aids, and their fitting are not covered. Charges to correct refractive error are not covered. But lenses are, following a cataract removal.

Dental Care

This provision does not apply to dental benefits, if any, provided under Section T.

Treatment of sound natural teeth, including their initial replacement, which are injured by accident is covered. The accident must occur while insured and the expenses

incurred within the next 12 months. Injuries resulting from chewing are never covered.

Diagnosis and treatment of temporo mandibular joint (TMJ Syndrome) is not covered.

Extractions of bony impacted teeth are covered.

Other treatment on or to the teeth, gums or jaws is not covered.

Weight Control

No benefits are payable for charges incurred for weight control, except for morbid obesity. Morbid obesity exists if you are 100 or more pounds over the average weight for a person of your height. In this case, benefits will be provided for 30 visits in any 12 consecutive months. Foods, vitamin and mineral supplements are not covered.

Birth Control and Infertility

Hospital charges and doctors' fees for surgery:

a. to correct the cause of infertility; or

b. for sterilization;

are covered. Surgery to reverse prior elective sterilization is not covered.

All other expenses for birth control and infertility also are not covered.

Cosmetic and Reconstructive Surgery

Cosmetic and reconstructive surgery is covered if it is part of, or follows, surgery for:

a. an injury, infection or disease that was medically treated when it occurred. The reconstruction must be on the same body part that was operated on; and

b. correction of a functional defect in a child insured from birth that results from congenital disease or anomaly.

Surgery of the nose that involves any cosmetic work is not covered. But benefits will be paid for treatment of an accident. The accident must have resulted in a nose fracture that was treated by a physician when it occurred.

Surgery involving the lower eye lids is not covered. Surgery involving only the upper lids is covered if the lids droop completely over the pupils.

All other charges that result from cosmetic surgery are not covered.

Spinal Column Treatment

For treatment of the spine, expenses incurred only in the first 30 visits of all covered practitioners in any 12 consecutive months are covered.

Hospital

A hospital is a licensed facility which:

a. has organized facilities, including diagnostic, for the care and treatment of sick and injured persons; and

b. provides 24 hour nursing service and medical supervision.

It is not a:

a. home for the aged, chronically ill or convalescent;

b. rest or nursing home;

c. skilled nursing facility; or

d. facility specializing in educational therapy for learning disabilities.

Skilled Nursing Facility

A skilled nursing facility:

a. supplies room, board and skilled nursing care 24 hours a day;

b. is under the full-time supervision of a physician or registered nurse;

c. requires, supervision of each patient by a physician;

d. is licensed; and

e. maintains complete medical files on each patient.

It is not, except incidentally, a:

a. place of rest;

b. place for the aged, drug addicts or alcoholics; or

c. hotel.

Residential Treatment Facility

A residential treatment facility:

a. provides specialized treatment for alcoholism, chemical dependency or drug addiction;

b. provides treatment on an in-patient basis;

c. is under the full-time supervision of a physician;

d. is licensed; and

e. does not qualify as a hospital.

It is not, except incidentally, a:

a. nursing home;

b. skilled nursing facility;

c. place of rest or hotel; or

d. facility specializing in educational therapy for learning disabilities.

Home Health Care Agency

A home health care agency is an organization which is primarily engaged in providing nursing and other therapeutic services, and is:

a. certified under Title XVIII of the Social Security Act; or

b. state licensed.

Usual and Customary Charges

Usual charges are those normally charged by the provider for the specific medical care or service rendered.

Customary charges are those most often made by providers for similar services in the same geographic area.

Physician

A physician is a licensed doctor of:

a. chiropractic;

b. dentistry;

c. medicine;

d. optometry;

e. osteopathy; and

f. podiatry

Medical Conversion Privilege

You may convert to an individual medical expense policy if:

a. your insurance terminates for any reason other than failure to pay any required premium or contribution;

b. you have been insured under the group policy, or any policy it replaced, for the prior three months;

c. you apply and pay the first premium within 45 days; and

d. you do not become insured under another successor group plan of the employer.

You do not have to prove that you are insurable.

The conversion policy will be issued to you. It may cover dependents that were insured under the group policy. If you die, the conversion policy will be issued to your spouse. If you don't have a spouse, it will be issued to the legal guardian of any minor or legally incompetent children.

Dependents who have reached age 19 will be issued their own conversion policy. This will not be done if they are incapable of self-sustaining employment because of mental retardation or physical handicap. Those who no longer meet the definition of "dependent" in Section A, may also convert.

The conversation policy will take effect on the date group coverage ceases. It will meet any statutory requirement for conversion. You may choose to pay the premium quarterly, semi-annually or annually.

The conversion policy will limit or exclude any condition that was limited or excluded by the group policy. Benefits may be reduced by the amount of any benefits payable under the group policy for expenses incurred after group coverage ceased.

Upon request, we will send you details of the benefits available.

We will not issue a conversion policy if you are insured for similar benefits under another plan on the date of conversion. This includes any other policy, welfare, prepayment or statutory program, which together with the

conversion policy, would result in overinsurance or duplication of benefits.

[LOGO] CHUBB[SM] LifeAmerica **SECTION W – PREGNANCY COVERAGE**

Pregnancy and Newborn Child Care

The mother's covered expenses that result from a pregnancy will be paid the same as an accident or sickness.

For a newborn child, expenses resulting from:

a. illness;

b. injury;

c. premature birth;

d. congenital defect; or

e. birth abnormality;

are included.

Nursery charges made by the hospital are also covered. There are no benefits for other pediatric care.

[LOGO] CHUBB[SM] LifeAmerica **SECTION Y – GENERAL POLICY PROVISIONS**

Your Beneficiary

You may change your beneficiary any time without his or her consent. To do so, send us a signed notice. The change will take effect on the day you sign it. An

acknowledgement will be sent to you. We are not responsible for payments made before we receive your written notice.

If you name more than one beneficiary and do not say how much each should get, they will share equally. If no named beneficiary survives you, or if you have not named a beneficiary, payment will be made, in the following order to:

a. your spouse;

b. your children;

c. your parents;

d. your estate.

If your beneficiary is a minor or legally incompetent, we will hold his or her share with interest until the age of majority is reached or a claim in writing is made by a legal guardian.

Notice and Proof of Accident and Health Claims

Written notice of sickness or injury must be given to us within 20 days after the covered loss occurred or starts. The notice should include enough information to identify you and should be sent to our claim office. We will then send you forms for filing proof of loss. If we fail to send the forms within 15 days after we receive your notice, you shall be considered to have satisfied the requirements for filing proof of loss. Proof of loss must describe the occurrence, character and extent of the loss.

For disability income claims, written proof of loss must be sent to us within 30 days after the start of the period

for which we are liable. For any other claim, proof of loss must be sent within 90 days after the date of loss.

If you can show that it was not reasonably possible to send notice within this time, it may be sent as soon as possible without affecting your claim.

Payment of Claims

Death benefits will be paid to the beneficiary named by you on a signed form. All other benefits will be paid to you.

Initial disability income claims will be paid no more than 30 days after we receive satisfactory proof of loss. Subsequent benefits will be paid at intervals of no more than 30 days apart.

All other claims will be paid no more than 60 days after we receive proof of loss.

Examination

While a claim is pending, we may have a physician, of our choice, examine the claimant. The examination will be at our expense. Where it is not illegal, we also have the right to have an autopsy.

Legal Actions

No action at law or in equity shall be brought to recover on the policy prior to the expiration of 60 days after written proof of loss has been sent. No action shall be brought more than six years after proof of loss is required to be sent.

Entire Contract

The contract consists of the policy, the Policyholder's application (a copy of which is attached to the policy) and the individual statements, if any, of the employees insured.

Incontestability

The validity of the policy cannot be contested, except for nonpayment of premiums, after one year from its issue date.

No statement made by you may be used to contest the validity of your insurance after it has been in force for two years and unless it is in writing signed by you and a copy has been given to you or your beneficiary.

Any statement made by you or the Policyholder shall be deemed representations and not warranties. No statement may be used to contest a claim, unless it is in writing.

Policy Changes

The policy may be changed any time by an agreement between us and the Policyholder. It is not necessary to have your consent or your beneficiary's to change the policy. Policy changes will be made by an amendment or an endorsement, signed by an officer of our company.

No agent may change the policy in any manner. We will not be bound by any promise or statement made by any agent that is not the policy.

No Effect on Workers' Compensation

The policy does not affect any requirement for workers' compensation insurance coverage.

Agency

The Policyholder and Employer act on their own behalf. They are not our agents.

Assignment of Death Benefits

You may assign your Life and Accidental Death Insurance under the policy. These interests include the right to name and change the beneficiary, to elect settlement options and to exercise the conversion privilege.

Policy Termination

We may cancel an Employer's insurance on a premium due date if less than:

a. 12 employees are insured;

b. 75% of the employees eligible are insured;

c. 75% of those employees with eligible dependents have them insured.

To do so, we will give written notice to the Employer at least 31 days in advance.

Records Required

The Employer must send us any information we need to administer the insurance. Relevant employer records may be inspected by us.

Insurance will not be continued beyond the date it ceased because the employer failed to report its termination.

Misstatement of Age

If the age given for an employee is incorrect, we will adjust the premium. If the policy terms would give a different insurance amount to a person of the correct age, this amount will also be adjusted. The premium adjustment will be based on the insurance amount for the correct age.

Individual Certificates

We will issue individual certificates to the Employer. They are to be given to each employee. The important features of the insurance protection are described in them.

Experience Refunds

If employees pay part of the cost of insurance and an experience refund is made; any amount paid that exceeds the Employer's share shall be applied to the sole benefit of the employees.

Initial Premium Rates

We will send the Employer a rider to the policy containing the initial premium rates. It will be signed by an officer or our company.

For life insurance, the average premium rate per $1,000 of insurance shall be determined based upon a premium

rate schedule which is in accordance with any applicable insurance law. A copy of this schedule will be furnished upon request.

Modification of Premium Rates

On the first policy anniversary and on each premium due date, we may change the rates with 31 days advance notice. The rates may also be changed any time the policy is amended.

Payment of Premiums

Premiums are payable by the Employer to the office named in the premium notice. They may be paid annually, semi-annually, quarterly or monthly. By mutual agreement, the mode may be changed with pro-rata adjustment.

The first premium is due on the policy effective date. Subsequent premiums are due on the same day of the month.

Grace Period

There is a 31 day grace period for payment of all premiums except the first, during which the policy will remain in force. The policy will terminate at the end of the grace period unless we receive written notice from the Employer to terminate it earlier. The Employer is responsible for the payment of a pro rata premium for the time the policy is in force during the grace period.

Premium for Changes in Insurance

Premiums for insurance taking effect during a policy month shall be charged from the first day of the policy month following the date the change took effect.

Premiums for insurance ceasing during a policy moth shall stop at the end of that month.

[LOGO] CHUBB[SM]
LifeAmerica

APPLICATION FOR GROUP INSURANCE

Group Policy Number: 330197 Effective Date: 8/1/86

Policyholder's Name and Address:
MOULDEN SUPPLY CO INC.
P.O. BOX 1247
3600 HWY. 80W.
JACKSON, MS 39215

AUG 22, 1986

This application replaces any prior one for the same policy.

The Policyholder has read the attached policy and accepts its terms.

No change may be made in the policy unless:

1. it is in writing; and

2. it is signed by an Officer of Colonial Life.

Signature of Policyholder's Representative:

X Ross & Yerger, Inc.

Title: Vice-President

Witness: X Carolyn B. Anderson

Date: 8/14/86

Plaintiff's Exhibit 2

This Proposal Especially Prepared For
MOULDEN SUPPLY CO INC

COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFITS

Nurses Charges	The plan pays 80% of the first $2000 plus 100% of excess over $2000.
Outpatient Psychiatric	Charges are payable at 50% to a maximum of $1000 in any 12 months.
Maternity Expenses	Payable as any other illness for the mother and nursery charges for the child.
Other Medical Expenses	80% of the first $5000 of all other covered charges, plus 100% thereafter.
Supplemental Accident	$300 prior to the deductible
Calendar Year Deductible	$100 per employee or dependent 300 maximum per family
Maximum Benefit	$2,000,000 per disability
Pre-existing Conditions	The maximum benefit is $500. However, for anyone insured under your existing policy, we will cover charges payable under our policy to the extent that the prior policy would have paid them.

	Cost of Benefits
4 Single Employees @ $54.97	$ 219.88
9 Families including employees @ $ 156.54	$ 1,408.86
Monthly Premium	$ 1,628.74

CHUBB LIFEAMERICA PARSIPPANY, NJ 07054
8 SYLVAN WAY/
P.O. BOX 216
(201) 455-1400